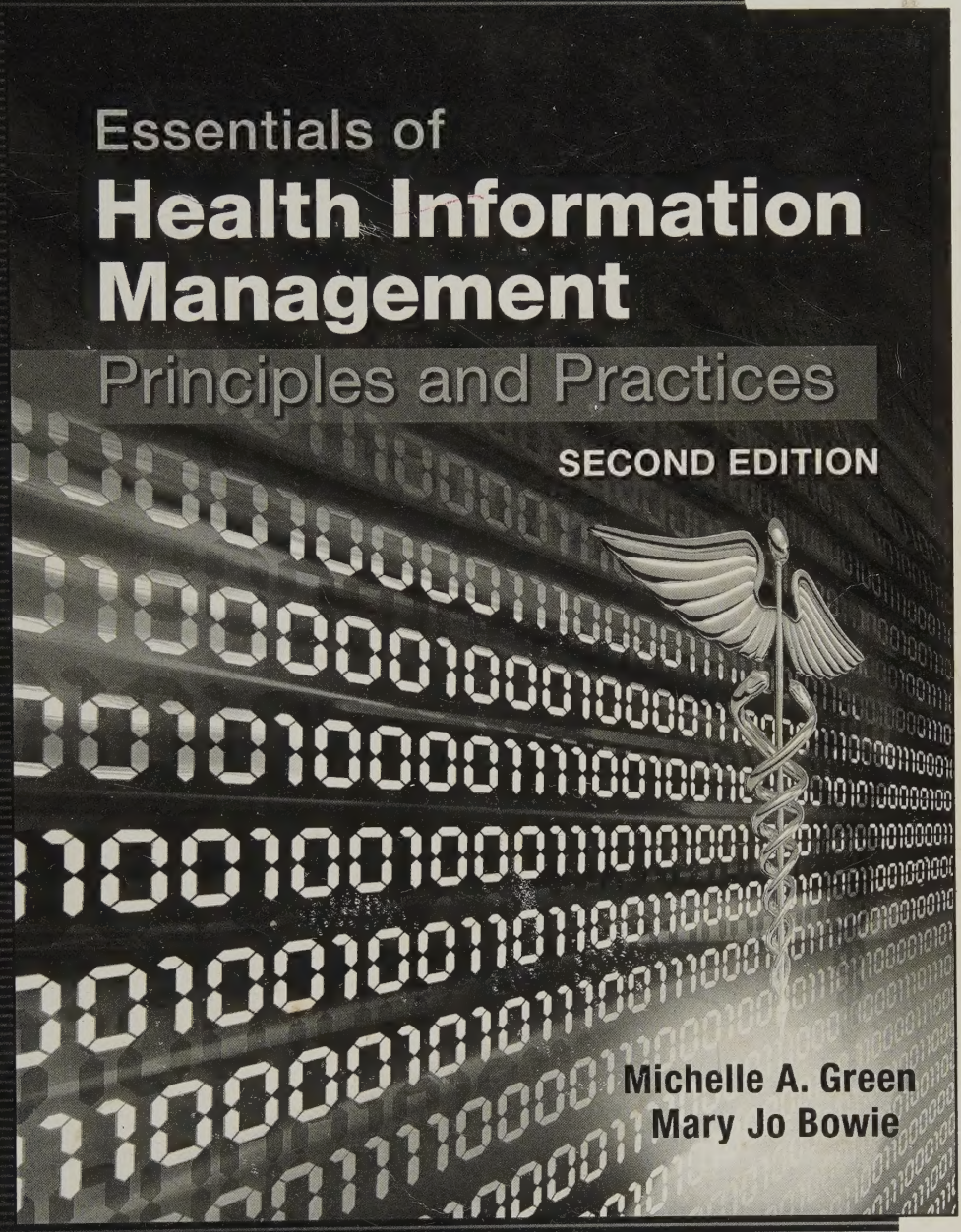
Instructor's Guide



MICHELLE A. GREEN I MARY JO BOWIE

Instructor's Manual to Accompany Essentials of Health Information Management: Principles and Practices

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Contents

Preface

This *Instructor's Manual* is organized in four sections. **Section I: Getting Started** contains a semester plan that can be modified for less than or greater than a 15-week semester, course outlines for lecture-based (3-credit) and lab-based (4-credit) courses, a class syllabus that can be modified and distributed to students on the first day of class, and chapter lesson plans.

Section II: Textbook Answer Keys contains answer keys for textbook exercises and reviews. These answer keys are also included in the WebTutor™.

Section III: Chapter Quizzes contain quizzes that are organized according to chapter.

NOTE: Chapter exams (and answers) in this Instructor's Manual contain questions that are different from those found in the computerized test bank on the Instructor's Resources CD-ROM. The chapter exams are the same as those included in the WebTutor™, which provides detailed feedback for the answers.

Teaching Tip: For ease of reference in locating the sections in the Instructor's Manual, consider placing a sticky note as a tab at the beginning of each section.

Section IV: Lab Manual Answer Keys contains answer keys for lab assignments. These answer keys are also included in the WebTutor™.

Remember! The *Lab Manual to Accompany Essentials of Health Information Management* contains assignments that refer to an online companion where resources (e.g., patient records) used for lab assignments are found. Go to http://www.delmarlearning.com, click on VISIT ONLINE COMPANION PRODUCT SITES, and enter Green in the Search box to locate this product's online companion.

StudyWare

The StudyWare™ CD-ROM located inside the back cover of the textbook allows students to review concepts learned in each chapter.

TEACHING TIP

StudyWare™ is an automated study guide for students. Instead of publishing (and selling!) a separate study guide of questions for students to complete, Delmar Cengage Learning bundles StudyWare with the textbook. Your students will notice that all types of questions are included in StudyWare (e.g., multiple choice, matching, true/false, and fill-in-the-blank). The software organizes the questions in a game format (e.g., fill-in-the-blank as hangman and crossword puzzles), which makes it fun for students to use.

ONLINE COMPANION

Additional resources are located online at http://www.delmarlearning.com/companions. Click on 'Allied Health' from the left navigation menu, and then click on the title of this book.

- Items listed as Student Resources are *not* password-protected. They include actual patient records in Adobe Portable Document Format (PDF), which students can use to practice quantitative analysis. (These records are also located in the *Lab Manual*). Adobe PDF files of assignments can be completed as forms and sent as email attachments to instructors for evaluation. Go to www.adobe.com to download the latest version of Adobe Reader to fill in forms. Students should be instructed to save completed forms as electronic files using the naming convention required by the instructor, such as GreenMPI.pdf for the master patient index card assignment.
- Items listed as Instructor Resources are password-protected. To access the protected instructor's content in the online companion (OLC), use the following information:

  Username: greenolc

  Password: enter

TEACHING TIP

The online companion (OLC) also contains revision files, which include changes to be made in the textbook and/or *Instructor's Manual* after publication (e.g., revised code numbers due to coding updates). You are welcome to e-mail the authors at delmarauthor@yahoo.com with questions or comments. The authors will respond to your e-mails, and appropriate corrections will be posted to the OLC to provide clarification about textbook and workbook content.

INSTRUCTOR RESOURCE CD-ROM

The Instructor Resources CD-ROM contains an electronic version of this *Instructor's Manual*, a computerized test bank (CTB), and instructor's slides in PowerPoint®. Go to http://www.delmarhealthcare.com or contact your Delmar Cengage Learning sales representative to order the Instructor Resources CD-ROM. These same supplements are also located at the password-protected Instructor's Resources link in the Online Companion.

WEBTUTOR™

WebTutor™ is available as a downloadable course cartridge or e-Pack for schools that use Blackboard, eCollege, WebCT, or another platform (e.g., Angel, Desire2Learn, Educator) as an online learning

management system. Go to http://webtutor.cengage.com to order WebTutor™.

WebTutor™ can be used to teach a course entirely online or to Web enhance an on-campus course. (Michelle Green, one of your textbook authors, teaches entirely online; but if she ever has an opportunity to teach a face-to-face course again, she will use WebTutor™ to administer quizzes and exams outside of class time in her college's testing center because that will add 5 hours or more of teaching time to her courses.)

Chapter exams in this *Instructor's Manual* contain the same questions as those included in WebTutor™. Detailed feedback is provided for incorrect answers when students take exams using WebTutor™. Administering quizzes and exams outside of class time is possible because students are provided with detailed feedback once they submit their quiz or exam. The instructor can delay viewing of detailed feedback until all students have submitted the quiz or exam. For a face-to-face course, the instructor can devote part of a class to discussing the exam results and questions about difficult exam items. For an online course, students can e-mail the instructor or post discussion comments about exam issues.

Section I

Preparing Your Course

This section contains a semester plan, course outlines, class syllabus, and chapter lesson plans. The semester plan is intended as a guide for organization of course content. The course outlines includes course objectives and division of subject matter. The course syllabus is intended for distribution to students on their first day of class and contains information about the instructor, course content, and classroom policies. A lesson plan is a teaching tool that allows the instructor to organize content to be taught in class, identify assignments to be completed by students, and prepare quizzes and exams for administration to students.

SEMESTER PLAN

To implement a semester plan for a 4-credit lecture/lab-based course that includes 90 hours of instruction (45 hours of lecture and 45 hours of lab) during a 14- or 15-week semester, include lab manual chapters (Tables I-1 and I-2). To implement a semester plan for a 3-credit lecture-based course that includes 45 hours of instruction (lecture only), exclude lab manual chapters from in-class instruction and consider requiring students to complete selected lab assignments as homework.

NOTE: The final examination would be administered during "finals week," which is typically held at the end of a 14- or 15-week semester.

Quizzes should be administered at least weekly, and it is helpful to students when an instructor consistently administers quizzes on the same day each week. (You may find that your colleagues administer them each Friday, so selecting Monday or Wednesday is also helpful to students.) During a week when a chapter (or unit) exam is administered, a quiz is optional. However, you will find that once students get used to taking weekly quizzes, they actually prefer this pedagogy (teaching philosophy) because it allows them to accrue lots of points during a course, and it requires them to routinely review course material. Consider implementing the policy of dropping the lowest quiz grade at the end of the semester. This allows an instructor to avoid administering time-consuming make-up quizzes because that zero is dropped for the student who misses a quiz.

Table I-1 Semester Plan for 14-Week Semester

Week	Activities
1–2	Chapter 1: Health Care Delivery Systems • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points) Chapter 2: Health Information Management Professionals • Quiz (20 points) • Homework Assignment (20 points) • Lab Assignment(s) (50–100 points)
3	Chapter 3: Health Care Settings • Quiz (20 points) • Homework (20 points) • Lab Assignment (field trip) Exam (Chapters 1–3) (100 points)
4	Chapter 4: The Patient Record: Hospital, Physician Office, and Alternate Care Settings • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points)
5	Chapter 5: Electronic Health Record • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points)
6	Chapter 6: Content of the Patient Record: Inpatient, Outpatient, and Physician Office • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points) Exam (Chapters 4–6) (100 points)
7–8	Chapter 7: Numbering & Filing Systems and Record Storage & Circulation • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points)
9–10	Chapter 8: Indexes, Registers, and Health Data Collection • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points) Exam (Chapters 7–8) (100 points)
11–12	Chapter 9: Legal Aspects of Health Information Management • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points)
13–14	Chapter 10: Coding and Reimbursement • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points) Exam (Chapters 9–10) (100 points)
Finals Week	Final Exam (Chapters 1–10) (100 points)

Table I-2 Semester Plan for 15-Week Semester

Week	Activities
1–2	Chapter 1: Health Care Delivery Systems • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points) Chapter 2: Health Information Management Professionals • Quiz (20 points) • Homework Assignment (20 points) • Lab Assignment(s) (50–100 points)
3	Chapter 3: Health Care Settings • Quiz (20 points) • Homework (20 points) • Lab Assignment (field trip) Exam (Chapters 1–3) (100 points)
4–5	Chapter 4: The Patient Record: Hospital, Physician Office, and Alternate Care Settings • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points)
6	Chapter 5: Electronic Health Record • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points)
7	Chapter 6: Content of the Patient Record: Inpatient, Outpatient, and Physician Office • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points) Exam (Chapters 4–6) (100 points)
8–9	Chapter 7: Numbering & Filing Systems and Record Storage & Circulation • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points)
10–11	Chapter 8: Indexes, Registers, and Health Data Collection • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points) Exam (Chapters 7–8) (100 points)
12–13	Chapter 9: Legal Aspects of Health Information Management • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points)
14–15	Chapter 10: Coding and Reimbursement • Quiz (20 points) • Homework (20 points) • Lab Assignment(s) (50–100 points) Exam (Chapters 9–10) (100 points)
Finals Week	Final Exam (Chapters 1–10) (100 points)

Homework assignments should be collected, reviewed, and a grade assigned. Students appreciate constructive mark up of their work, and assigning points allows the instructor to conveniently track whether a student has submitted all assignments. Assigning a grade also communicates to students how important it is that they complete homework assignments.

NOTE: You can administer the Chapter 10 exam as part of the final exam, allowing more time for instruction during the last week of class.

COURSE OUTLINE

A course outline is an administrative document developed prior to teaching a course for the first time, and it should be updated according to your school's schedule, when changing textbooks, or prior to an accreditation survey visit, whichever comes first. It is helpful to include your school's identification information at the top of the course outline (in case a transfer school requests a copy from you).

NOTE: Figure I-1 contains a course outline intended for a 4-credit lecture- and lab-based course. Figure I-2 contains a 3-credit lecture-based course outline.

CLASS SYLLABUS

The course syllabus (Figure I-3) is distributed to students on the first day of class, and the instructor should review its contents:

- Instructor name and contact information
- Course name and description
- Course objectives
- Class policies
- Content topics and due dates

LESSON PLAN

A lesson plan is an organizational tool created by the instructor prior to teaching a chapter or unit. The instructor identifies content to be covered in class, resources to be used, assignments to be completed by students, and material that will be included on quizzes and exams. Lesson plans are created for each chapter (or unit) about one week prior to teaching chapter (or unit) content so that the instructor can properly prepare teaching materials and exams used for instruction.

NOTE: A lesson plan for each chapter is located in this section of this *Instructor's Manual*.

COURSE NAME: Introduction to Health Information Management
COURSE NUMBER: MEDR 1114
COURSE FORMAT: 3 hours of lecture and 3 hours of laboratory per week
PREREQUISITES: None
SEMESTER OFFERED: Fall and Spring

COURSE DESCRIPTION: A study of recordkeeping practices in the hospital and physician's office. Emphasis is placed on hospital and medical staff organization, patient record content, procedures in filing, numbering and retention of patient records, quantitative analysis, release of patient information, forms control and design, indexes and registers, reimbursement, regulatory and accrediting agencies, and alternate health care delivery systems.

COURSE OBJECTIVES: At the conclusion of this course, the student should be able to:
1. Introduce health information management concepts common to allied health professionals.
2. Describe characteristics of health care delivery and settings in the United States.
3. Delineate career opportunities for health information management professionals.
4. Describe types of patient records, including documentation issues associated with each.
5. Describe numbering and filing systems and record storage and circulation methods.
6. Explain indexes, registers, and health data collection.
7. Introduce legal aspects of health information management.
8. Provide an overview of coding and reimbursement issues.

TEXTBOOKS: Green, Michelle A., and Mary Jo Bowie. *Essentials of Health Information Management.* Delmar Learning.
Green, Michelle A., and Mary Jo Bowie. *Lab Manual to Accompany Essentials of Health Information Management.* Delmar Learning.

	DIVISION OF SUBJECT MATTER	Lecture	Lab
I.	Health Care Delivery Systems	3	3
	A. Health Care Delivery		
	B. Health Care Facility Ownership		
	C. Licensure, Regulation, and Accreditation		
II.	Health Information Management Professionals	3	3
	A. Careers		
	B. Professional Ethics		
	C. Professional Practice Experience		
	D. Professional Associations		
III.	Health Care Settings	3	3
	A. Acute Care Settings		
	B. Ambulatory and Outpatient Care		
	C. Behavioral Health Care Facilities		
	D. Home Care and Hospice		
	E. Managed Care		
	F. Federal, State, and Local Health Care		
IV.	The Patient Record: Hospital, Physician Office, and Alternate Care Settings	6	6
	A. Definition and Purpose of the Patient Record		
	B. Provider Documentation Responsibilities		
	C. Development of the Patient Record		
	D. Patient Record Formats		
	E. Archived Records		
	F. Patient Record Completion Responsibilities		
V.	Electronic Health Record	3	3
	A. Evolution of Electronic Health Records		
	B. Electronic Health Record Systems		
	C. Regional Health Information Organizations		
	D. Components of Electronic Health Record Systems Used in Health Care		
VI.	Content of the Patient Record: Inpatient, Outpatient, and Physician Office	6	6
	A. General Documentation Issues		
	B. Hospital Inpatient Record—Administrative Data		
	C. Hospital Inpatient Record—Clinical Data		
	D. Hospital Outpatient Record		
	E. Physician Office Record		
	F. Forms Control and Design		
VII.	Numbering & Filing Systems and Record Storage & Circulation	3	3
	A. Numbering Systems		
	B. Filing Systems		
	C. Filing Equipment		
	D. File Folders		
	E. Filing Controls		
	F. Loose Filing		
	G. Circulation Systems		
	H. Security of Health Information		
VIII.	Indexes, Registers, and Health Data Collection	3	3
	A. Indexes		
	B. Registers		
	C. Case Abstracting		
	D. Health Data Collection		
IX.	Legal Aspects of Health Information Management	6	6
	A. Legal and Regulatory Terms		
	B. Maintaining the Patient Record in the Normal Course of Business		
	C. Confidentiality of Information and HIPAA Privacy and Security Provisions		
	D. Legislation that Impacts Health Information Management		
X.	Coding and Reimbursement	3	3
	A. Nomenclatures and Classification Systems		
	B. Third-Party Payers		
	C. Health Care Reimbursement Systems		
XI.	Assessment	6	6
	Totals	45	45

Figure I-1 Sample Course Outline for 4-Credit Lecture/Lab-Based Course

COURSE NAME: Introduction to Health Information Management
COURSE NUMBER: MEDR 1113
COURSE FORMAT: 3 hours of lecture
PREREQUISITES: None
SEMESTER OFFERED: Fall and Spring

COURSE DESCRIPTION: A study of recordkeeping practices in the hospital and physician's office. Emphasis is placed on hospital and medical staff organization, patient record content, procedures in filing, numbering and retention of patient records, quantitative analysis, release of patient information, forms control and design, indexes and registers, reimbursement, regulatory and accrediting agencies, and alternate health care delivery systems.

COURSE OBJECTIVES: At the conclusion of this course, the student should be able to:
1. Introduce health information management concepts common to allied health professionals.
2. Describe characteristics of health care delivery and settings in the United States.
3. Delineate career opportunities for health information management professionals.
4. Describe types of patient records, including documentation issues associated with each.
5. Describe numbering and filing systems and record storage and circulation methods.
6. Explain indexes, registers, and health data collection.
7. Introduce legal aspects of health information management.
8. Provide an overview of coding and reimbursement issues.

TEXTBOOKS: Green, Michelle A., and Mary Jo Bowie. *Essentials of Health Information Management.* Delmar Learning.
Green, Michelle A., and Mary Jo Bowie. *Lab Manual to Accompany Essentials of Health Information Management.* Delmar Learning.

	DIVISION OF SUBJECT MATTER	Lecture
I.	Health Care Delivery Systems	3
	A. Health Care Delivery	
	B. Health Care Facility Ownership	
	C. Licensure, Regulation, and Accreditation	
II.	Health Information Management Professionals	3
	A. Careers	
	B. Professional Ethics	
	C. Professional Practice Experience	
	D. Professional Associations	
III.	Health Care Settings	3
	A. Acute Care Settings	
	B. Ambulatory and Outpatient Care	
	C. Behavioral Health Care Facilities	
	D. Home Care and Hospice	
	E. Managed Care	
	F. Federal, State, and Local Health Care	
IV.	The Patient Record: Hospital, Physician Office, and Alternate Care Settings	6
	A. Definition and Purpose of the Patient Record	
	B. Provider Documentation Responsibilities	
	C. Development of the Patient Record	
	D. Patient Record Formats	
	E. Archived Records	
	F. Patient Record Completion Responsibilities	
V.	Electronic Health Record	3
	A. Evolution of Electronic Health Records	
	B. Electronic Health Record Systems	
	C. Regional Health Information Organizations	
	D. Components of Electronic Health Record Systems Used in Health Care	
VI.	Content of the Patient Record: Inpatient, Outpatient, and Physician Office	6
	A. General Documentation Issues	
	B. Hospital Inpatient Record—Administrative Data	
	C. Hospital Inpatient Record—Clinical Data	
	D. Hospital Outpatient Record	
	E. Physician Office Record	
	F. Forms Control and Design	
VII.	Numbering & Filing Systems and Record Storage & Circulation	3
	A. Numbering Systems	
	B. Filing Systems	
	C. Filing Equipment	
	D. File Folders	
	E. Filing Controls	
	F. Loose Filing	
	G. Circulation Systems	
	H. Security of Health Information	
VIII.	Indexes, Registers, and Health Data Collection	3
	A. Indexes	
	B. Registers	
	C. Case Abstracting	
	D. Health Data Collection	
IX.	Legal Aspects of Health Information Management	6
	A. Legal and Regulatory Terms	
	B. Maintaining the Patient Record in the Normal Course of Business	
	C. Confidentiality of Information and HIPAA Privacy and Security Provisions	
	D. Legislation that Impacts Health Information Management	
X.	Coding and Reimbursement	3
	A. Nomenclatures and Classification Systems	
	B. Third-Party Payers	
	C. Health Care Reimbursement Systems	
XI.	Assessment	6
	Totals	45

Figure I-2 Sample Course Outline for 3-Credit Lecture Course

Essentials of Health Information Management (HLTH 101) (Lecture)
Name of Professor:
Office Location:
Office Phone:
Email Address:

COURSE DESCRIPTION: A study of recordkeeping practices in the hospital and physician's office. Emphasis is placed on hospital and medical staff organization, patient record content, procedures in filing, numbering and retention of patient records, quantitative analysis, release of patient information, forms control and design, indexes and registers, reimbursement, regulatory and accrediting agencies, and alternate health care delivery systems.

COURSE OBJECTIVES: At the conclusion of this course, the student should be able to:
1. Introduce health information management concepts common to allied health professionals.
2. Describe characteristics of health care delivery and settings in the United States.
3. Delineate career opportunities for health information management professionals.
4. Describe types of patient records, including documentation issues associated with each.
5. Describe numbering and filing systems and record storage and circulation methods.
6. Explain indexes, registers, and health data collection.
7. Introduce legal aspects of health information management.
8. Provide an overview of coding and reimbursement issues.

ATTENDANCE POLICY: Students are expected to be in attendance for all classes. Contact the instructor prior to an anticipated absence or as soon as possible after class if the absence was unexpected. Homework assignments are due on the day you return to class if you were absent on the day due.

EXAM POLICIES: Make-up quizzes are not administered due to class absence; however, the lowest quiz grade will be dropped at the end of the semester. A unit exam may be taken if absent, if you make arrangements to do so prior to discussion of exam results with the class. Please be aware that exam results are distributed during the next class. A comprehensive final exam will be administered during finals week.

TESTING ARRANGEMENTS: If you have a documented learning disability that allows you to take exams at the Learning Assistance Center, deliver the appropriate form to my office or place it in my mailbox. This is a confidential way of communicating with me so that proper arrangements will be made to accommodate you. There is no need to discuss these arrangements with me in the classroom, thus ensuring that classmates will be unaware of them. If you are concerned that classmates will notice that you are not in attendance during an exam administered in class, please be assured that each student will be concerned with their performance on the exam and your absence will go unnoticed. (If such an observation is made by a classmate, be assured that I will communicate that expressing such concerns about another student is unnecessary.)

CLASS PARTICIPATION: Students are encouraged to ask questions during class and to comment on topics discussed as they relate to content covered. Comments unrelated to content will be politely discouraged due to the volume of material to be covered during the semester. Classmates are expected to be tolerant of each others' views. In addition, to ensure that all students have an opportunity to participate during class discussions, students need to count slowly to 5 before answering a question. Everyone processes thoughts differently and many of us need to think through what we want to say before we express ourselves. You may have taken previous courses during which a few students consistently monopolized discussion. Counting to 5 before answering will help ensure that all students have the opportunity to participate during class.

TEXTBOOKS: Green, Michelle A., and Mary Jo Bowie. *Essentials of Health Information Management.* Delmar Learning.
Green, Michelle A., and Mary Jo Bowie. *Lab Manual to Accompany Essentials of Health Information Management.* Delmar Learning.

TOPICS:
Health Care Delivery Systems
Health Information Management Professionals
Health Care Settings
UNIT 1 EXAM
The Patient Record: Hospital, Physician Office, and Alternate Care Settings
Electronic Health Record
Content of the Patient Record: Inpatient, Outpatient, and Physician Office
UNIT 2 EXAM
Numbering & Filing Systems and Record Storage & Circulation
Indexes, Registers, and Health Data Collection
UNIT 3 EXAM
Legal Aspects of Health Information Management
UNIT 4 EXAM
Coding and Reimbursement
UNIT 5 EXAM
FINAL EXAM

Figure I-3 Sample Course Syllabus

LESSON PLAN

Chapter 1: Health Care Delivery Systems

Time:
- 3–6 hours instructor preparation
- 3 hours in-class lecture time
- 3 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- Health Care Delivery
- Health Care Facility Ownership
- Licensure, Regulation, and Accreditation

Overview: This chapter presents an overview of the development of health care, beginning with ancient medicine through current delivery in the United States. You will learn that health care delivery has been greatly impacted by escalating costs, resulting in medical necessity requirements (to justify acute care hospitalizations), review of appropriateness of admissions, and requirement for administration of quality and effective treatments. Today, patients routinely undergo preadmission testing (PAT) on an outpatient basis instead of being admitted as a hospital inpatient, and the performance of outpatient testing and surgical procedures has increased due to health care technological advances (e.g., lap-aroscopic appendectomies). Health care consumers are better educated and demand higher-quality, more cost-effective health care, and the focus is on primary and preventive care.

Objectives:
- Define key terms
- Summarize the history of medicine and the delivery of health care in the United States.
- List programs and services offered as part of the continuum of care.
- Differentiate between for-profit and not-for-profit health care facility ownership.
- Interpret the authority and responsibility associated with a health care facility's organizational structure.
- Define and provide examples of licensure, regulation, and accreditation.

	Task	Resource
Prior to class:	■ Read textbook, and prepare lecture notes ■ Review answers to chapter exercises and review ■ Select homework and lab-based assignments ■ Prepare course syllabus ■ Prepare chapter quiz	■ *Essentials of Health Information Management (HIM),* Chapter 1 ■ *Instructor's Manual to Accompany Essentials of HIM,* Chapter 1 ■ *Lab Manual to Accompany Essentials of HIM,* Chapter 1 ■ *Instructor's Manual, Essentials of HIM,* Section I ■ *Instructor's Manual, Essentials of HIM,* Chapter 1
Class 1:	■ Distribute and explain course syllabus ■ Point out major features of textbook ■ Review WebTutor features (if applicable) ■ Assign Chapter 1 as reading assignment	■ Prepared course syllabus ■ *Essentials of HIM,* Preface ■ *Essentials of HIM,* Preface ■ *Essentials of HIM,* Chapter 1
Class 2:	■ Lecture on Chapter 1 content ■ Encourage students to create flash cards ■ Assign chapter exercises/review as homework	■ Lecture notes prepared, *Essentials of HIM,* Chapter 1 ■ *Essentials of HIM,* Chapter 1 ■ *Essentials of HIM,* Chapter 1
Class 3:	■ Review previous class lecture, and answer student questions about chapter content ■ Collect homework (and grade) ■ Administer chapter quiz ■ Assign Chapter 2 as reading assignment	■ Ask students to identify key topics and issues from previous class lecture ■ *Instructor's Manual, Essentials of HIM,* Chapter 1 ■ *Instructor's Manual, Essentials of HIM,* Chapter 1 ■ *Essentials of HIM,* Chapter 2
Lab 1:	■ Point out major features of lab manual ■ Communicate assignments to be accomplished during lab, and explain how each is to be completed ■ Rotate among students as they complete lab assignments to provide individual assistance ■ Consider reviewing rough draft work during lab and allowing students to submit final draft at the beginning of the next lab class	■ *Lab Manual to Accompany Essentials of HIM,* Preface ■ *Lab Manual to Accompany Essentials of HIM,* Chapter 1

Assessment:
- Homework assignments
- Chapter quiz
- In-class participation
- Lab assignments

Chapter 2: Health Information Management Professionals

Time:
- 3–6 hours instructor preparation
- 3 hours in-class lecture time
- 3 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- Careers
- Professional Practice Experience
- Join Your Professional Association

Overview: This chapter will focus on a variety of career opportunities in health care and health information management, the role of the professional practice experience (or externship), the importance of joining professional organizations, the interpretation of professional codes of ethics, the impact of networking with other professionals, and the development of opportunities for professional advancement.

Objectives:
- Define key terms
- Differentiate among health information management career opportunities
- Identify professional associations available to health care professionals
- Name the benefits of completing an academic professional practice experience

	Task	Resource
Prior to class:	■ Read textbook, and prepare lecture notes ■ Review answers to chapter exercises and review ■ Select homework and lab-based assignments ■ Prepare chapter quiz	■ *Essentials of Health Information Management (HIM),* Chapter 2 ■ *Instructor's Manual to Accompany Essentials of HIM,* Chapter 2 ■ *Lab Manual to Accompany Essentials of HIM,* Chapter 2 ■ *Instructor's Manual, Essentials of HIM,* Chapter 2
Class 4:	■ Lecture on Chapter 2 content ■ Encourage students to create flash cards ■ Assign chapter exercises/review as homework	■ Lecture notes prepared, *Essentials of HIM,* Chapter 2 ■ *Essentials of HIM,* Chapter 2 ■ *Essentials of HIM,* Chapter 2
Class 5:	■ Review previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 2 content ■ Collect homework (and grade)	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 2 ■ *Instructor's Manual, Essentials of HIM,* Chapter 2
Class 6:	■ Review previous class lecture, and answer student questionst about chapter conten ■ Administer chapter quiz ■ Assign Chapter 3 as reading assignment	■ Ask students to identify key topics and issues from previous class lecture ■ *Instructor's Manual, Essentials of HIM,* Chapter 2 ■ *Essentials of HIM,* Chapter 3
Lab 2:	■ Communicate assignments to be accomplished during lab, and explain how each is to be completed ■ Rotate among students as they complete lab assignments to provide individual assistance ■ Consider reviewing rough draft work during lab and allowing students to submit final draft at the beginning of the next lab class	■ *Lab Manual to Accompany Essentials of HIM,* Chapter 2

Assessment:
- Homework assignments
- Chapter quiz
- In-class participation
- Lab assignments

Chapter 3: Health Care Settings

Time:
- 3–6 hours instructor preparation
- 3 hours in-class lecture time
- 3 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- Acute Care Facilities (Hospitals)
- Ambulatory and Outpatient Care
- Behavioral Health Care Facilities
- Home Care and Hospice
- Long-Term Care
- Managed Care
- Federal, State, and Local Health Care

Overview: Prior to 1983 when the diagnosis-related groups (DRGs) prospective payment system (PPS) was implemented as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), patients typically received health care services as hospital inpatients where they stayed until they were well enough to be discharged home. Diagnosis-related groups (DRGs) classify inpatient hospital cases into groups that are expected to consume similar hospital resources. Medicare originally introduced this classification system to pay for inpatient hospital care, with other payers adopting this PPS in subsequent years. Under DRGs, inpatients are discharged once the acute phase of illness has passed, and they are often transferred to other types of health care, such as outpatient care, skilled care facilities, rehabilitation hospitals, home health care, and so on. The transfer facilities provide an appropriate level of health care in a safe and cost-effective manner after the patient's attending physician (with the assistance of discharge planners, case managers, social workers, nurses, and others) has determined which facility is best by evaluating the patient's medical condition, special needs, and treatment goals.

Objectives:
- Define key terms
- List and define hospital categories, and identify types of hospital patients
- Differentiate among freestanding, hospital-based, and hospital-owned ambulatory care settings
- Distinguish among various types of behavioral health care facilities
- Detail services provided by home care and hospice agencies
- Differentiate among the various managed care models
- Describe federal, state, and local health care facilities

	Task	Resource
Prior to class:	■ Read textbook, and prepare lecture notes ■ Review answers to chapter exercises and review ■ Select homework and arrange field trip for students ■ Prepare chapter quiz	■ *Essentials of Health Information Management (HIM),* Chapter 3 ■ *Instructor's Manual to Accompany Essentials of HIM,* Chapter 3 ■ *Lab Manual to Accompany Essentials of HIM,* Chapter 3 ■ *Instructor's Manual, Essentials of HIM,* Chapter 3
Class 7:	■ Lecture on Chapter 3 content ■ Encourage students to create flash cards ■ Assign chapter exercises/review as homework	■ Lecture notes prepared, *Essentials of HIM,* Chapter 3 ■ *Essentials of HIM,* Chapter 3 ■ *Essentials of HIM,* Chapter 3
Class 8:	■ Review previous class lecture, and answer studentt questions about chapter conten ■ Continue lecture on Chapter 3 content ■ Collect homework (and grade)	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 3 ■ *Instructor's Manual, Essentials of HIM,* Chapter 3
Class 9:	■ Exam (Chapters 1–3) ■ Assign Chapter 4 as reading assignment	■ Computerized Test Bank (in Electronic Classroom Manager) ■ *Essentials of HIM,* Chapter 4
Lab 3:	■ Accompany students on field trip to local facility	■ *Lab Manual to Accompany Essentials of HIM,* Chapter 3

Assessment:
- Homework assignments
- Chapter quiz
- In-class participation
- Lab assignments

Chapter 4: The Patient Record: Hospital, Physician Office, and Alternate Care Settings

Time:
- 3–6 hours instructor preparation
- 3 hours in-class lecture time
- 3 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- Definition and Purpose of the Patient Record
- Provider Documentation Responsibilities
- Development of the Patient Record
- Patient Record Formats
- Archived Records
- Patient Record Completion Responsibilities

Overview: The manual and electronic patient record has many purposes, but one goal: documentation of patient care. Hospital inpatient records have traditionally served as a documentation source and business record for patient care information; however, alternate care facilities that provide behavioral health, home health, hospice, outpatient, skilled nursing, and other forms of care also serve as the documentation source for patient care information. Regardless of the type of care provided, a health care facility's patient records contain similar content (e.g., consent forms) and format features (e.g., all records contain patient identification information).

Objectives:
- Differentiate among various types of patient records
- Summarize the purpose of the patient record
- Provide examples of administrative and clinical data
- Delineate provider documentation responsibilities
- Summarize the development of the patient record
- Explain the correct method for correcting documentation
- Discuss the importance of authentication of records
- Compare alternative storage methods
- Summarize patient record completion responsibilities

	Task	Resource
Prior to class:	■ Read textbook, and prepare lecture notes ■ Review answers to chapter exercises and review ■ Select homework and arrange field trip for students ■ Prepare chapter quiz	■ *Essentials of Health Information Management (HIM),* Chapter 4 ■ *Instructor's Manual to Accompany Essentials of HIM,* Chapter 4 ■ *Lab Manual to Accompany Essentials of HIM,* Chapter 4 ■ *Instructor's Manual, Essentials of HIM,* Chapter 4
Class 10:	■ Review exam results and answer student questions ■ Lecture on Chapter 4 content ■ Encourage students to create flash cards ■ Assign chapter exercises/review as homework	■ Exam (Chapters 1–4) ■ Lecture notes prepared, *Essentials of HIM,* Chapter 4 ■ *Essentials of HIM,* Chapter 4 ■ *Essentials of HIM,* Chapter 4
Class 11:	■ Review previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 4 content ■ Collect homework (and grade)	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 4 ■ *Instructor's Manual, Essentials of HIM,* Chapter 4
Class 12:	■ Continue lecture on Chapter 4 content ■ Assign Chapter 5 as reading assignment	■ Lecture notes prepared, *Essentials of HIM,* Chapter 4 ■ *Essentials of HIM,* Chapter 5
Lab 4:	■ Communicate assignments to be accomplished during lab, and explain how each is to be completed ■ Rotate among students as they complete lab assignments to provide individual assistance ■ Consider reviewing rough draft work during lab and allowing students to submit final draft at the beginning of the next lab class	■ *Lab Manual to Accompany Essentials of HIM,* Chapter 4

Assessment:
- Homework assignments
- Chapter quiz
- In-class participation
- Lab assignments

Chapter 5: Electronic Health Records

Time:
- 6 to 9 hours instructor preparation
- 3 hours in-class lecture time
- 3 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- Evolution of Electronic Health Records
- Electronic Health Record Systems
- Regional Health Information Organizations
- Components of Electronic Health Record Systems Used in Health Care

Overview: This chapter presents an overview of electronic health records. A brief history of terms that relate to electronic records is given. Various applications that are parts of electronic records are discussed as well as Regional Health Information Organizations.

Objectives:
- Define key terms.
- Distinguish between computerized patient records, electronic patient records, and electronic health records.
- Discuss electronic record implementation issues.
- Define and discuss the importance of regional health information organizations.
- Identify the administrative and clinical applications found in electronic health records.

	Task	Resource
Prior to Class:	■ Read textbook, and prepare lecture notes. ■ Review answers to chapter exercises and review. ■ Select homework. ■ Prepare chapter quiz.	■ *Essentials of Health Information Management (HIM)*, Chapter 5 ■ *Instructor's Manual to Accompany Essentials of HIM*, Chapter 5 ■ *Lab Manual to Accompany Essentials of HIM*, Chapter 5 ■ *Instructor's Manual, Essentials of HIM*, Chapter 5
Class 13:	■ Lecture on Chapter 5 content. ■ Encourage students to create flash cards. ■ Assign chapter exercises/review as homework.	■ Lecture notes prepared, *Essentials of HIM*, Chapter 5 ■ *Essentials of HIM*, Chapter 5
Class 14:	■ Review previous class lecture and answer student . questions about chapter content ■ Continue lecture on Chapter 5. ■ Collect homework and grade.	■ Ask students to identify key topics and issues from previous class lecture. ■ Lecture notes prepared, *Essentials of HIM*, Chapter 5 ■ *Instructor's Manual, Essentials of HIM*, Chapter 5
Class 15:	■ Review previous class lecture and answer student questions about chapter content. ■ Continue lecture on Chapter 5. ■ Assign Chapter 6 as reading assignment.	■ Ask students to identify key topics and issues from previous class lecture. ■ Lecture notes prepared, *Essentials of HIM*, Chapter 5 ■ *Instructor's Manual, Essentials of HIM*, Chapter 5
Lab 5:	■ Communicate assignments to be accomplished during lab and explain how each lab is to be completed. ■ Rotate among students as they complete lab assignments to provide individual assistance. ■ Consider reviewing rough draft work during lab and allowing students to submit final draft at the beginning of the next lab class.	■ *Lab Manual to Accompany Essentials of HIM*, Chapter 5

Assessment:
- Homework assignment
- Chapter quiz
- In-class participation
- Lab assignment

Chapter 6: Content of the Patient Record: Inpatient, Outpatient, and Physician Office

Time:
- 6–9 hours instructor preparation
- 6 hours in-class lecture time
- 6 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- General Documentation Issues
- Hospital Inpatient Record—Administrative Data
- Hospital Inpatient Record—Clinical Data
- Hospital Outpatient Record
- Physician Office Record
- Forms Control and Design

Overview: Health care providers (e.g., hospitals, physician offices, and so on) are responsible for maintaining a record for each patient who receives health care services. If accredited, the provider must comply with standards that impact patient recordkeeping (e.g., The Joint Commission). In addition, federal and state laws and regulations (e.g., Medicare Conditions of Participation) provide guidance as to patient record content requirements (e.g., inpatient, outpatient, and so on). To appropriately comply with accreditation standards and federal and state laws and regulations, most facilities establish a forms design and control procedure along with a forms committee to manage the process.

Objectives:
- Define key terms
- Explain general documentation issues that impact all patient records
- Differentiate between administrative, and clinical data collected on patients
- List the contents of inpatient, outpatient, and physician office records
- Detail forms design and control requirements, including the role of the forms committee

	Task	Resource
Prior to class:	■ Read textbook, and prepare lecture notes ■ Review answers to chapter exercises and review ■ Select homework and arrange field trip for students ■ Prepare chapter quiz	■ *Essentials of Health Information Management (HIM)*, Chapter 6 ■ *Instructor's Manual to Accompany Essentials of HIM*, Chapter 6 ■ *Lab Manual to Accompany Essentials of HIM*, Chapter 6 ■ *Instructor's Manual, Essentials of HIM*, Chapter 6
Class 16:	■ Lecture on Chapter 6 content ■ Encourage students to create flash cards ■ Assign chapter exercises/review as homework	■ Lecture notes prepared, *Essentials of HIM*, Chapter 6 ■ *Essentials of HIM*, Chapter 6 ■ *Essentials of HIM*, Chapter 6
Class 17:	■ Review previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 6 content ■ Collect homework (and grade)	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM*, Chapter 6 ■ *Instructor's Manual, Essentials of HIM*, Chapter 6
Class 18:	■ Review previous class lecture, and answer student questionst about chapter conten ■ Continue lecture on Chapter 6 content	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM*, Chapter 6
Class 19:	■ Review previous class lecture, and answer student questionst about chapter conten ■ Continue lecture on Chapter 6 content	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM*, Chapter 6
Class 20:	■ Review previous class lecture, and answer student questionst about chapter conten ■ Continue lecture on Chapter 6 content	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM*, Chapter 6
Class 21:	■ Exam (Chapters 4–6) ■ Assign Chapter 7 as reading assignment	■ Computerized Test Bank (in Electronic Classroom Manager) ■ *Essentials of HIM*, Chapter 7
Labs 6 and 7:	■ Communicate assignments to be accomplished during lab, and explain how each is to be completed ■ Rotate among students as they complete lab assignments to provide individual assistance ■ Consider reviewing rough draft work during lab and allowing students to submit final draft at the beginning of the next lab class	■ *Lab Manual to Accompany Essentials of HIM*, Chapter 6

Assessment:
- Homework assignments
- Chapter quiz
- In-class participation
- Lab assignments

Chapter 7: Numbering & Filing Systems and Record Storage & Circulation

Time:
- 6–9 hours instructor preparation
- 3 hours in-class lecture time
- 3 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- Numbering Systems
- Filing Systems
- Filing Equipment
- File Folders
- Filing Controls
- Loose Filing
- Circulation Systems
- Security of Health Information

Overview: The patient record documents a patient's past medical history, services rendered (e.g., to diagnose conditions), and procedures performed (e.g., to treat problems), and a well-organized numbering and filing system is essential to the effective storage and retrieval of patient records. In addition to facilitating continuity of patient care among health care providers, the patient record supports services and procedures provided to patients (e.g., third-party reimbursement) and defends health care providers accused of medical malpractice. All of these activities require that patient records be easily accessible and retrieved in a timely fashion.

Objectives:
- Define key terms
- Explain the differences among serial, unit, and serial-unit numbering systems
- Name, define and organize records according to alphabetic and numeric filing systems.
- Define, organize records according to alphabetic and numeric filing systems
- Cite advantages and disadvantages in the use of alphabetic and numeric filing systems
- Explain the rules, and arrange records for alphabetic, straight numerical, terminal-digit, and middle-digit filing
- Compare the types of filing equipment used to store file folders and calculate storage needs.
- Discuss the components of a file folder, including color-coding, fastener position, preprinted material, and scoring and reinforcement
- Explain the procedure for organizing and managing loose filing
- Describe circulation systems that are used to transport patient records
- Identify security measures that occur to safeguard patient records and information from theft, fire, and water damage

	Task	Resource
Prior to class:	■ Read textbook, and prepare lecture notes ■ Review answers to chapter exercises and review ■ Select homework and arrange field trip for students ■ Prepare chapter quiz	■ *Essentials of Health Information Management (HIM),* Chapter 7 ■ *Instructor's Manual to Accompany Essentials of HIM,* Chapter 7 ■ *Lab Manual to Accompany Essentials of HIM,* Chapter 7 ■ *Instructor's Manual, Essentials of HIM,* Chapter 7
Class 22:	■ Review exam results and answer student questions ■ Lecture on Chapter 7 content ■ Encourage students to create flash cards ■ Assign chapter exercises/review as homework	■ Exam (Chapters 4–6) ■ Lecture notes prepared, *Essentials of HIM,* Chapter 7 ■ *Essentials of HIM,* Chapter 7 ■ *Essentials of HIM,* Chapter 7
Class 23:	■ Review previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 7 content ■ Collect homework (and grade)	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 7 ■ *Instructor's Manual, Essentials of HIM,* Chapter 7
Classes 24:	■ Review previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 7 content	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 7
Labs 8:	■ Communicate assignments to be accomplished during lab, and explain how each is to be completed ■ Rotate among students as they complete lab assignments to provide individual assistance ■ Consider reviewing rough draft work during lab and allowing students to submit final draft at the beginning of the next lab class	■ *Lab Manual to Accompany Essentials of HIM,* Chapter 7

Assessment:
- Homework assignments
- Chapter quiz
- In-class participation
- Lab assignments

Chapter 8: Indexes, Registers, and Health Data Collection

Time:
- 6–9 hours instructor preparation
- 3 hours in-class lecture time
- 3 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- Indexes
- Registers
- Case Abstracting
- Health Data Collection

Overview: Indexes and registers (or registries) allow health information to be maintained and retrieved by health care facilities for the purpose of education, planning, research, and so on. According to *The American Heritage® Dictionary of the English Language,* an index "serves to guide, point out, or otherwise facilitate reference, especially an alphabetized list of names, places, and subjects treated in a printed work, giving the page or pages on which each item is mentioned." A common use is to locate a term in the index of a textbook and refer to the page number indicated. In health care, a master patient index is maintained, which allows for the retrieval of patient demographic information and the medical record number so the patient's record can be retrieved.

According to *The American Heritage® Dictionary of the English Language,* a register is maintained as "a formal or official recording of items, names, or actions." You may be familiar with church registers that record births, baptisms, marriages, deaths, and burials. Health care facilities also maintain registers to record admissions, discharges, births, deaths, operations, and other events. Registers are organized in chronological order, contain patient data, and are used for reference or control purposes. When used as a reference, they provide information about workload (e.g., number of births). As a control function, registers track patient data (e.g., number control log, which contains numbers assigned to patients). A registry is an organized system for the collection, storage, retrieval, analysis, and dissemination of information on individuals who have either a particular disease, a condition (e.g., a risk factor) that predisposes to the occurrence of a health-related event, or prior exposure to substances or circumstances known or suspected to cause adverse health effects (e.g., official record book such as a death register).

Indexes and registers can be automated or manual. Automated indexes and registers are computerized, which allows information to be easily and quickly retrieved for administrative planning, data collection, patient care management, quality of patient care, and the study of diseases and their outcomes. Manual indexes and registers require the hand posting of information to ledger cards and log books, resulting in a cumbersome process when information retrieval becomes necessary.

Objectives:
- Define key terms
- Identify indexes, registers, and registries maintained by health care facilities and state and federal agencies
- Explain the uses of indexes, registers, and registries
- Determine case abstracting requirements for patient records
- Discuss the characteristics of health data collection

	Task	Resource
Prior to class:	■ Read textbook, and prepare lecture notes ■ Review answers to chapter exercises and review ■ Select homework and arrange field trip for students ■ Prepare chapter quiz	■ *Essentials of Health Information Management (HIM),* Chapter 8 ■ *Instructor's Manual to Accompany Essentials of HIM,* Chapter 8 ■ *Lab Manual to Accompany Essentials of HIM,* Chapter 8 ■ *Instructor's Manual, Essentials of HIM,* Chapter 8
Class 25:	■ Review exam (Chapter 4–6) with students ■ Lecture on Chapter 8 content ■ Encourage students to create flash cards ■ Assign chapter exercises/review as homework	■ Exam (Chapter 4–6) results ■ Lecture notes prepared, *Essentials of HIM,* Chapter 8 ■ *Essentials of HIM,* Chapter 8 ■ *Essentials of HIM,* Chapter 8
Class 26:	■ Review previous class lecture, and answer student questiont about chapter content ■ Continue lecture on Chapter 8 content ■ Collect homework (and grade) ■ Administer chapter quiz	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 8 ■ *Instructor's Manual, Essentials of HIM,* Chapter 8 ■ *Instructor's Manual, Essentials of HIM,* Chapter 8
Class 27:	■ Review quiz, previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 8 content	■ Quiz results. Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 8
Class 28:	■ Review previous class lecture, and answer student questions about chapter conte ■ Continue lecture on Chapter 8 content ■ Administer chapter quiz	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 8 ■ *Instructor's Manual, Essentials of HIM,* Chapter 8
Class 29:	■ Review quiz, previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 8 content	■ Quiz results. Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 8
Class 30:	■ Exam (Chapters 7–8) ■ Assign Chapter 9 as reading assignment	■ Computerized Test Bank (on Electronic Classroom Manager) ■ *Essentials of HIM,* Chapter 8
Labs 9 and 10:	■ Communicate assignments to be accomplished during lab, and explain how each is to be completed ■ Rotate among students as they complete lab assignments to provide i ndividual assistance ■ Consider reviewing rough draft work during lab and allowing students to submit final draft at the beginning of the next lab class	■ *Lab Manual to Accompany Essentials of HIM,* Chapter 8

Assessment:
- Homework assignments
- Chapter quiz
- In-class participation
- Lab assignments

Chapter 9: Legal Aspects of Health Information Management

Time:
- 6–9 hours instructor preparation
- 6 hours in-class lecture time
- 6 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- Legal and Regulatory Terms
- Maintaining the Patient Record in the Normal Course of Business
- Confidentiality of Information and HIPAA Privacy and Security Provisions
- Legislation that Impacts Health Information Management
- Release of Protected Health Information

Overview: This chapter discusses legal aspects of health information management (HIM) covered as part of an introductory course in the following academic programs: coding and reimbursement, health information administration, health information technology, medical assistant, medical billing, medical office administration, medical secretary, medical transcription, and so on.

Objectives:
- Define key terms.
- Identify and define health information legal and regulatory terms
- Maintain the patient record in the normal course of business
- Maintain confidentiality of protected health information (PHI)
- Comply with HIPAA privacy and security provisions
- Interpret legislation that impacts health information management
- Appropriate release of protected health information (PHI)

	Task	Resource
Prior to class:	■ Read textbook, and prepare lecture notes ■ Review answers to chapter exercises and review ■ Select homework and arrange field trip for students ■ Prepare chapter quiz	■ *Essentials of Health Information Management (HIM),* Chapter 9 ■ *Instructor's Manual to Accompany Essentials of HIM,* Chapter 9 ■ *Lab Manual to Accompany Essentials of HIM,* Chapter 9 ■ *Instructor's Manual, Essentials of HIM,* Chapter 9
Class 31:	■ Review exam (Chapters 6–7) with students ■ Lecture on Chapter 9 content ■ Encourage students to create flash cards ■ Assign chapter exercises/review as homework	■ Exam (Chapters 6–7) results ■ Lecture notes prepared, *Essentials of HIM,* Chapter 9 ■ *Essentials of HIM,* Chapter 9 ■ *Essentials of HIM,* Chapter 9
Class 32:	■ Review previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 9 content ■ Collect homework (and grade) ■ Administer chapter quiz	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 9 ■ *Instructor's Manual, Essentials of HIM,* Chapter 9 ■ *Instructor's Manual, Essentials of HIM,* Chapter 9
Class 33:	■ Review quiz, previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 9 content	■ Chapter quiz results. Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 9
Class 34:	■ Review previous class lecture, and answer student questions bout chapter content ■ Continue lecture on Chapter 9 content ■ Administer chapter quiz	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 9 ■ *Instructor's Manual, Essentials of HIM,* Chapter 9
Class 35:	■ Review quiz, previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 9 content	■ Chapter quiz results. Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 9
Class 36:	■ Exam (Chapter 9) ■ Assign Chapter 10 as reading assignment	■ Computerized Test Bank (on Electronic Classroom Manager) ■ *Essentials of HIM,* Chapter 9
Labs 11 and 12:	■ Communicate assignments to be accomplished during lab, and explain how each is to be completed ■ Rotate among students as they complete lab assignments to provide individual assistance ■ Consider reviewing rough draft work during lab and allowing students to submit final draft at the beginning of the next lab class	■ *Lab Manual to Accompany Essentials of HIM,* Chapter 9

Assessment:
- Homework assignments
- Chapter quiz
- In-class participation
- Lab assignments

Chapter 10: Coding and Reimbursement

Time:
- 6–9 hours instructor preparation
- 3 hours in-class lecture time
- 3 hours in-class lab time (if laboratory component is included as part of course)

Topics:
- Nomenclatures and Classification Systems
- Third-Party Payers
- Health Care Reimbursement Systems

Overview: Health care providers and third-party payers use nomenclatures and classification systems to collect, store, and process data for a variety of purposes (e.g., reimbursement processing). The Centers for Medicare & Medicaid Services (CMS) is an administrative agency of the Department of Health & Human Services (DHHS). One of its many functions is to manage implementation of Medicare prospective payment systems (PPS), payment systems, fee schedules, and exclusions. Typically, third-party payers adopt payment systems, fee schedules, and exclusions after Medicare has implemented them; payers modify them to suit their needs. Hospitals use a chargemaster to record encounter data about ambulatory care, and the chargemaster review process is crucial to the recording of accurate data. Physician offices use an encounter form (or superbill) for the same purpose. Hospitals submit UB-92 claims to payers for inpatient and ambulatory care encounters, and physicians submit CMS-1500 claims for office encounters. Most health care settings participate in electronic data interchange (EDI) with third-party payers and clearinghouses.

Objectives:
- Define key terms
- Differentiate between nomenclatures and classifications, and state uses of each
- List and explain differences among third-party payers
- List and define health care reimbursement systems

	Task	Resource
Prior to class:	■ Read textbook, and prepare lecture notes ■ Review answers to chapter exercises and review ■ Select homework and arrange field trip for students ■ Prepare chapter quiz	■ *Essentials of Health Information Management (HIM),* Chapter 10 ■ *Instructor's Manual to Accompany Essentials of HIM,* Chapter 10 ■ *Lab Manual to Accompany Essentials of HIM,* Chapter 10 ■ *Instructor's Manual, Essentials of HIM,* Chapter 10
Class 37:	■ Review exam (Chapter 9) with students ■ Lecture on Chapter 10 content ■ Encourage students to create flash cards ■ Assign chapter exercises/review as homework	■ Exam (Chapter 9) results ■ Lecture notes prepared, *Essentials of HIM,* Chapter 10 ■ *Essentials of HIM,* Chapter 10 ■ *Essentials of HIM,* Chapter 10
Class 38:	■ Review previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 10 content ■ Collect homework (and grade) ■ Administer chapter quiz	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 10 ■ *Instructor's Manual, Essentials of HIM,* Chapter 10 ■ *Instructor's Manual, Essentials of HIM,* Chapter 10
Class 39:	■ Review quiz, previous class lecture, and answer student questions about chapter conten ■ Continue lecture on Chapter 10 content	■ Chapter quiz results. Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 10
Class 40:	■ Review previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 10 content ■ Administer chapter quiz	■ Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 10 ■ *Instructor's Manual, Essentials of HIM,* Chapter 10
Class 41:	■ Review quiz, previous class lecture, and answer student questions about chapter content ■ Continue lecture on Chapter 10 content	■ Chapter quiz results. Ask students to identify key topics and issues from previous class lecture ■ Lecture notes prepared, *Essentials of HIM,* Chapter 10
Class 42:	■ Exam (Chapter 10) ■ Instruct students on final exam preparation	■ Computerized Test Bank (on Electronic Classroom Manager) ■ *Essentials of HIM,* Chapters 1–10
Labs 13 & 14:	■ Communicate assignments to be accomplished during lab, and explain how each is to be completed ■ Rotate among students as they complete lab assignments to provide individual assistance ■ Consider reviewing rough draft work during lab and allowing students to submit final draft at the beginning of the next lab class	■ *Lab Manual to Accompany Essentials of HIM,* Chapter 10

Assessment:
- Homework assignments
- Chapter quiz
- In-class participation
- Lab assignments

Section II

Textbook Answer Keys

Chapter 1

Health Care Delivery Systems

EXERCISE 1-1 History of Medicine and Health Care Delivery

1. 1847 AMA founded
2. 1898 Association of Hospital Superintendents was founded, later becoming the AHA in 1906
3. 1913 ACS founded
4. 1965 Medicare and Medicaid enacted
5. 1985 COBRA enacted
6. 1996 HIPAA passed
7. 1997 SCHIP established, as mandated by Title XXI of the Balanced Budget Act of 1997
8. 2001 CMS was created, replacing HCFA
9. 2002 QIOs replace PROs
10. 2003 MMA implemented

EXERCISE 1-2 Continuum of Care

1. T
2. T
3. T
4. F
5. F

EXERCISE 1-3 Health Care Facility Ownership

1. teaching hospital
2. resident
3. for-profit
4. government-supported
5. 60

EXERCISE 1-4 Health Care Facility Organizational Structure

1. Dermatology
2. Obstetrics
3. Ophthalmology
4. Thoracic Surgery
5. Orthopedics
6. Quality Management Committee
7. Executive Committee
8. Tissue Review Committee
9. Joint Conference Committee
10. Ethics Committee

EXERCISE 1-5 Licensure, Regulation, and Accreditation

Matching

1. 1
2. 1
3. 1
4. 2
5. 2

Short Answer

6. Accreditation Association for Ambulatory Health Care
7. American Osteopathic Association
8. Community Health Accreditation Program
9. Centers for Medicare and Medicaid Services
10. National Committee for Quality Assurance

CHAPTER REVIEW

True/False

1. T
2. F
3. F
4. T
5. F
6. F
7. F
8. T
9. T
10. T

Multiple Choice

11. d
12. c
13. a
14. a
15. d
16. b
17. d
18. d
19. b
20. c

Fill-In-The-Blank

21. National Committee for Quality Assurance
22. better, higher-quality more cost-effective
23. modern
24. Hippocratic Oath
25. monks and nuns
26. radium
27. The Pennsylvania Hospital
28. primary care
29. for-profit
30. written authorization, court order

Short Answer

31. A hospital m ultidisciplinary committee consists of representation from hospital departments and the medical staff. Various hospital committees include: Disaster Control, Drug Utilization Review (or Pharmacy and Therapeutics), Education, Finance, Forms, and Risk Management.

32. Diagnosis and procedure indexes are computer-generated printouts, sequenced by code number, that contain patient information. The indexes are used to retrieve records for quality management and other purposes.

33. An electronic signature describes all technology options available that can be used to sign a document. A digital signature is a type of electronic signature that uses public key cryptography to attach an alphanumeric number to a document that is unique to the document and to the person signing the document.

34. Services that a HIM department may contract out include:

    Cancer Registry: Certified tumor registrars (CTRs) organize and assess cancer registry programs, assist in the preparation of an annual report, and perform the following technical functions: cancer case abstracting, patient care evaluation and research studies, follow-up for survival analysis, management of cancer data collection, and survey preparation/compliance with ACS standards.

    Coding: Credentialed coding staff provide out-source coding support (e.g., for facilities experiencing coding staff shortages), perform coding compliance audits to determine accuracy of codes and to ensure that Office of Inspector General (OIG) guidelines are met, review chargemasters for accuracy, and conduct APC & DRG validation studies (to determine accuracy of APC and DRG assignment).

    Document Conversion: Specialty companies convert paper-based documents and data to computer-based patient record (CPR) format using scanning technology to automate data entry, publish records on the Internet, manage messaging systems, and provide storage solutions (including providing immediate access to information).

    Master Patient Index Duplication Review: Companies use software to identify, correct, and eliminate duplicate MPI records, increasing patient identification accuracy and patient care safety.

    Medical Transcription: Local and national medical transcription services provide Internet-based and pick-up/delivery of dictation and transcribed reports for health care facilities.

    Release of Information Processing: Use of an outside copy service to process release of information requests.

    Trauma Registry: Credentialed professionals create and maintain a registry of all trauma admissions, deaths in the emergency department due to trauma, recording data elements for each entry that becomes part of a national registry developed by the ACS.

35. Accreditation is the voluntary compliance with standards that are created by accrediting agencies as measurements of a health care organization's level of performance in specific areas. A regulation is the interpretation of a law and is written by a regulatory agency such as the Centers for Medicare & Medicaid Services. It is mandatory that regulations be followed by a health care organization.

36. The Joint Commission accredits the following types of organizations: ambulatory care providers, assisted-living facilities, behavioral health care organizations, clinical laboratories, health care networks, home care organizations, hospitals, nursing homes, and other long-term care facilities.

37. Once the coding function is completed, abstracting of patient cases is performed to enter codes and other pertinent information (e.g., patient identification data, admission/discharge dates, and so on) utilizing computer software. The purpose of abstracting is to generate statistical reports and disease/procedure indexes, which are used for administrative decision making and quality management purposes.

38. Primary care services include preventive and acute care services and are provided by a general practitione or other health professional who has first contact with a patient. Primary care services include annual phys ical examinations, early detection of diseases, family planning, health education, immunizations, treatmen of minor illnesses and injuries, and vision and hearing screening. Secondary care services are provided b medical specialists or hospital staff members to a patient whose primary care was provided by a genera practitioner who first diagnosed or treated the patient. Examples of secondary care services include spe cialty consultations, orthopedic services for a patient referred because of a hip fracture, and a woman re ferred by a family practitioner to an OB-GYN because she is pregnant.
39. Proprietary hospitals are for-profit facilities owned by corporations, partnerships, or private foundations Voluntary hospitals are not-for-profit facilities owned by religious or other voluntary groups.
40. The purposes of record circulation include retrieval for inpatient readmission, scheduled and unschedule outpatient clinic visits, authorized quality management studies, and education/research.

Chapter 2

Health Information Management Professionals

EXERCISE 2-1 Careers

The student will submit a word-processed document that summarizes career information.

EXERCISE 2-2 Professional Practice Experience

The student will submit a form that identifies prospective professional practice sites.

EXERCISE 2-3 Join Your Professional Association

The student will join their professional association. (This might be an optional assignment due to student financial constraints.)

CHAPTER REVIEW

True/False

1. F
2. T
3. T
4. F
5. F

Multiple Choice

6. a
7. a
8. d
9. d
10. c

Fill-In-The-Blank

11. coding
12. faster than average
13. Medical Association of Billers
14. certified medical assistant, registered medical assistant
15. code of ethics

Short Answer

16. She should obtain certification as a Certified Coding Specialist-Physician-based (CCS-P) or Certified Professional Coder (CPC).
17. Coding specialists have the opportunity to work at home because health care employers have partnered with Internet-based application service providers (ASP). An ASP is a third-party entity that manages and distributes software-based services and solutions to customers across a wide area network (WAN).
18. Health information managers are considered experts in managing patient health information and medical records, administering computer information systems, and coding diagnoses and procedures for health care services provided to patients.
19. Students receive on-the-job experience prior to graduation, which assists them in obtaining permanent employment, and facilities have the opportunity to participate in and improve the formal education process. Quite often, students who complete professional practices are later employed by the facility at which they completed the experience.
20. Student benefits of joining a professional association include:
    - Receiving publications, often in the form of professional journals
    - Web site access for members only
    - Networking with members through professional practices and job placement
    - Reduced certification exam fees
    - Eligibility for scholarships and grants

Chapter 3

Health Care Settings

EXERCISE 3-1 Acute Care Facilities (Hospitals)

1. multi-hospital
2. bed size, state
3. short-term, long-term

EXERCISE 3-2 Ambulatory/Outpatient Care Facilities

1. T
2. F
3. T
4. T
5. F

EXERCISE 3-3 Behavioral Health Care Facilities

1. day treatment program
2. chemical dependency
3. therapeutic group home
4. short-term
5. residential treatment

EXERCISE 3-4 Home Care and Hospice

1. Canes, crutches, IV supplies, hospital beds, ostomy supplies, oxygen, prostheses, walkers, wheelchairs
2. Assistance with daily living activities such as bathing, dressing, grooming, going to the toilet, mealtime assistance, travel training, and accessing recreation services
3. Chemotherapy, drug therapy, hydration therapy, pain management, total parenteral nutrition

EXERCISE 3-5 Long-Term Care

1. Assisted Living Facility
2. Continuing Care Retirement Communities
3. Intermediate Care Facility
4. Residential Care Facility
5. Skilled Nursing Facility

EXERCISE 3-6 Managed Care

1. Exclusive Provider Organization
2. Health Maintenance Organization
3. Integrated Provider Organization
4. Point-of-Service Plan
5. Preferred Provider Organization

CHAPTER REVIEW

True/False

1. T
2. F
3. T
4. F
5. T
6. F
7. F

Multiple Choice

8. a
9. d
10. b
11. a
12. b

Fill-In-The-Blank

13. rehabilitation facility
14. skilled care
15. palliative, curative
16. behavioral health care
17. pediatricians

Short Answer

18. The goal of hospice is palliative rather than curative. The types of services provided in hospice programs include comprehensive medical and supportive social, emotional, and spiritual care for terminally ill patients and their families.
19. Two methods for evaluating the quality of health care provided to inmates include assessments by the federal Health Services Division's (HSD) Office of Policy, Planning, and Quality Management and Accreditation by the Joint Commission on Accreditation of Healthcare Organizations.
20. General hospitals admit patients for a range of problems and provide emergency, medical, and surgical care. Specialty hospitals treat particular populations of patients or specific diseases. Rehabilitation hospitals treat patients who are diagnosed with trauma or a disease and need to learn how to function again. Behavioral health care hospitals treat individuals with mental health diagnoses. An adult day care center would be of help in this situation. Mary could receive care and supervision at this setting while Sally is at work.
21. An adult day care center would be of help in this situation. Mary could receive care and supervision at this setting while Sally is at work.
22. Ancillary services are diagnostic and therapeutic services provided to hospital inpatients and outpatients. Examples include laboratory, physical therapy, occupational therapy, and radiology.

Chapter 4

The Patient Record: Hospital, Physician Office, and Alternate Care Settings

EXERCISE 4-1 Definition and Purpose of the Patient Record

1. C
2. A
3. A
4. C
5. C
6. A
7. A
8. C
9. A
10. C
11. C
12. C
13. A
14. A
15. C

EXERCISE 4-2 Provider Documentation Responsibilities

1. author, accurate
2. electronic signature
3. countersignature
4. signatures, initials
5. documented, done
6. The entry should be corrected by drawing a single line through the word "right." The date, time, and signature of the provider making the correction should be recorded. The reason for the error, "entry made in error," should be recorded. The correct information, "left upper," should be written close to the word "right."
7. authorized
8. do not use
9. audit trial
10. telephone order

EXERCISE 4-3 Development of the Patient Record

1. The universal chart order saves time in processing discharged patient records because reorganizing reports in a different chart order is unnecessary.
2. Preadmission testing reduces inpatient lengths of stay.
3. Preadmission tests include chest X-rays, electrocardiograms, and laboratory testing such as blood typing, urinalysis, CBC, and CHEM-12.
4. Nursing admission documentation requirements include completion of a nursing assessment that documents the patient's history, current medications, vital signs, nursing notes, and graphic charts.
5. The purpose of the discharge summary is to document the care provided to the patient during the inpatient hospitalization along with reason for hospitalization, course of treatment and patient's response to treatment, patient's condition at discharge, and discharge/follow-up instructions.

EXERCISE 4-4 Patient Record Format

1. problem-oriented record
2. problem list
3. secondary
4. source-oriented
5. SOAP

EXERCISE 4-5 Archived Records

1. F
2. T
3. F
4. T
5. F

EXERCISE 4-6 Patient Record Completion Responsibilities

1. concurrent analysis
2. physicians, documentation
3. chart deficiencies, quantitative analysis
4. discharged patient records, storage
5. 24, 30, 24

Case Study

Progress note 1

Abbreviations not on abbreviation list: S, O, R, W, ACE, A, P, IHD. The abbreviations S, P, and R are not used in the correct context.

Progress note 2

Abbreviations not on abbreviation list: O, R, W, A, HT and P. Abbreviations R and P are not used in the correct context.

Progress note 3

Abbreviations not on The Joint Commission List: Q.D.

Students should discuss that an abbreviation list is important to prevent the misinterpretation of abbreviations.

CHAPTER REVIEW

True/False

1. F
2. T
3. F
4. F
5. T
6. T
7. F
8. T

Fill-In-The-Blank

9. abbreviations, symbols
10. addendum
11. tentative
12. attending physician
13. secondary sources
14. signature legend
15. clinical

Multiple Choice

16. d
17. a
18. a
19. b
20. c

Short Answer

21. Countersignatures are needed when nurses and other authorized personnel document information for a physician, such as telephone orders.
22. To correct an error in a paper-based medical record, the provider should draw a single line through the incorrect information, making sure that the original entry remains legible. Then, date, time, and sign the corrected entry. The reason for the error should also be documented in a location close to the original entry. Corrected information should be entered as close to the original information as possible.

    To correct an error in an electronic medical record (EMR), store both the original and corrected entries in the EMR. Enter the date, time, reason for the correction, and authentication of the person making correction. Maintain an audit trail of all changes. (A number of different methods can be used to correct an error in an EMR, depending on the type of information to be corrected.)
23. The inpatient record is generated in the health care facility's admission office and may include preadmission testing (PAT) information, which is combined with demographic data, consents, and financial information. The record is forwarded to the nursing unit where a nursing assessment is completed and physician orders are reviewed. The attending physician documents an admission history, physical examination, and physician orders for patient services. Additional services are documented by various departments in the form of progress notes, transcribed reports, and so on. At patient discharge, the attending physician documents a discharge summary.
24. The source-oriented record (SOR) maintains reports according to source of documentation, each of which has a section that is labeled and divided into sections (e.g., nursing, radiology, physician orders, progress notes).
25. Secondary purposes of the patient record include evaluation of the quality of patient care, providing information to third-party payers for reimbursement, and serving the medicolegal interests of the patient, facility, and providers of care.

Chapter 5

Electronic Health Records

EXERCISE 5-1 Evolution of Electronic Health Records

Fill-In-The-Blank

1. clinical data repository
2. longitudinal patient record
3. personal health record
4. HL7
5. electronic health record

Case Study

Student responses will vary but should include some of the following:

1. The planning team should have representatives from administration including CEO, finance, HIM, admissions, and clinical areas of the facility.
2. The student should be able to defend his or her answer based on information obtained from within the chapter.
3. Questions could include:
   - What is the time line for implementation?
   - What components of the patient record will be automated?
   - What is the budget for the electronic record system?
   - Which staff members should be involved in the process?

CHAPTER REVIEW

True/False

1. F
2. F
3. T
4. F
5. T

Multiple Choice

6. D
7. A
8. B
9. D
10. B
11. B
12. C
13. B
14. A
15. B

Short Answer

16. Students should outline the advantages and disadvantages as discussed in Table 5-1.
17. Steps include:
    - Remove all staples, paper clips, or fasteners from documents
    - Ensure that the patient's name and medical record number appear on each page.
    - Repair any page that is torn.
18. HIM professionals will contribute to the transition to electronic record systems because they have the knowledge of the documentation needs of facilities. HIM professionals understand the organization of the paper record and can therefore provide guidance for screen development for electronic systems.
19. The quality of patient care will be improved. Medication errors will be reduced, repeat testing will be eliminated, and documentation will be accessed by numerous providers at the same time.
20. The student should identify three of the following clinical applications: Patient monitoring, pharmacy, laboratory, radiology, nursing, and medical documentation. The student should briefly describe the application according to the information found in Chapter 5 under the heading Administrative and Clinical Electronic Health Record Applications.

Chapter 6

Content of the Patient Record: Inpatient, Outpatient, and Physician Office

EXERCISE 6-1 General Documentation Issues

1. T
2. T
3. T
4. F

EXERCISE 6-2 Hospital Inpatient Record—Administrative Data

Matching

1. C
2. I
3. F
4. I
5. C
6. I

True/False

7. T
8. F
9. F
10. F
11. T

EXERCISE 6-3 Hospital Inpatient Record—Clinical Data

1. clinical resume, course of treatment
2. history, history of the present illness
3. 30 days, interval history
4. physicians orders, doctors orders
5. standing, routine
6. ambulance report
7. examining the patient, advice
8. integrated progress notes, same section
9. progress notes, PACU (or recovery room)
10. operative report
11. tissue or pathology report
12. ancillary reports
13. nursing care plan
14. postpartum record
15. macroscopic, autopsy

EXERCISE 6-4 Hospital Outpatient Records

True/False

1. F
2. F
3. T
4. T
5. T

Fill-In-The-Blank

6. Uniform Ambulatory Care Data Set
7. encounter
8. first-listed diagnosis
9. outpatient visits
10. ancillary service visit or occasion of service

EXERCISE 6-5 Physician Office Record

1. D
2. C
3. A
4. E
5. B

EXERCISE 6-6 Forms Control and Design

1. T
2. F
3. T
4. F
5. T

CHAPTER REVIEW

Fill-In-The-Blank

1. graphic sheet
2. obstetric
3. anesthetic agent
4. preoperative, postoperative
5. pathology/tissue report

Multiple Choice

6. b
7. a
8. a
9. a
10. c
11. a
12. a
13. c
14. b
15. b

True/False

16. F
17. T
18. F
19. F
20. T

Chapter 7

Numbering & Filing Systems and Record Storage & Circulation

EXERCISE 7-1 Numbering Systems

1. a
   Rationale: When a patient is assigned two different numbers for two encounters and the records are filed in *separate folders* in the file system, the Serial Numbering System is being used.
2. d
   Rationale: When all records are housed in one folder for family members, the Unit–Family Numbering System is being used.
3. b
   Rationale: When a patient is assigned the same number for multiple encounters at the same health care facility, the Unit Numbering System is being used.
4. e
   Rationale: When a patient's medical record number is created by using their name and date of birth, the Unit–Social Security Numbering System is being used.
5. c
   Rationale: When a patient is assigned two different numbers for two encounters and the records are filed in the *same folder* in the file system, the Serial-Unit Numbering System is being used.

EXERCISE 7-2 Filing Systems

1.

6	Mr. John Franco	11	Steven James Smith
12	Steven John Smith	9	Pamela LaBelle
3	Geraldine Daven	7	Mary Alice Kane
4	Marie DeAngelo	1	Andrew Bittner

2	Andrew C. Bittner			10	Patricia Francis Leska
5	William James DeBella			8	Sister Theresa Mary Kane

2.

1	456123	10	789456	2	456124
6	561238	3	456128	7	561240
5	561237	11	789457	12	789459
9	789450	4	456130	8	562140

3. a. M-460
   Rationale: "M" is the first letter of the last name; therefore, do not assign a number to it. Assign 4 to the first "ll" (because just one code number is assigned when two or more key letters or their equivalents occur together). Assign 6 to the "r." Assign 0 as the last number because you've run out of letters in the name. (Do not assign numbers to vowels or the letters "w, h, y.")
   b. B-650
   Rationale: "B" is the first letter of the last name; therefore, do not assign a number to it. Assign 6 to the "r" and 5 to the "n." Assign 0 as the last number because you've run out of letters in the name. (Do not assign numbers to vowels or the letters "w, h, y.")
   c. S-612
   Rationale: "S" is the first letter of the last name; therefore, do not assign a number to it. Do not assign numbers to "c" or "z" because they are key letters or equivalents that occur together (next to the "S"), which are represented by the "S" in the code. Assign 6 to the "r" and 1 to the "b." Assign 2 to the "ck" (because just one code number is assigned when two or more key letters or their equivalents occur together). (Do not assign numbers to vowels or the letters "w, h, y.")
   d. D-435
   Rationale: "D" is the first letter of the last name; therefore, do not assign a number to it. Assign 4 to the "l," 3 to t he "t," and 5 to the "n." (Do not assign numbers to vowels or the letters "w, h, y.")
   e. P-665
   Rationale: "P" is the first letter of the last name; therefore, do not assign a number to it. Assign 6 to the first "r" and 6 to the second "r" because they are separated by a "y." Assign 5 to the "n." (Do not assign numbers to vowels or the letters "w, h, y.")

4.

2	30-50-06	9	30-40-94	7	88-39-20
4	11-30-20	6	84-39-20	5	10-31-20
10	54-40-94	1	01-01-04	11	12-40-96
12	40-50-96	3	34-50-06	8	89-45-20

5.

10	30-50-06	7	30-40-94	5	88-39-20
2	11-30-20	4	84-39-20	3	10-31-20
8	54-40-94	1	01-01-04	6	12-40-96
12	40-50-96	11	34-50-06	9	89-45-20

6. A centralized filing system organizes patient records in one central location under the control of the facility's health information department. A decentralized filing system organizes patient records throughout the facility, in patient care areas under the control of the department that creates them.

EXERCISE 7-3 Filing Equipment

1. d
2. a
3. b
4. c
5. 56 units

EXERCISE 7-4 File Folders

1. 45-79-80 pink, orange
   99-9-57 light blue, dark green
   67-40-46 light green, dark blue
   83-92-84 pink, light green
   59-02-31 purple, red
2. Fastener position and scoring & reinforcement
3. Color-coding
4. Adhesive strip, embedded, heat bonded, DocuClip
5. Point stock

EXERCISE 7-5 Filing Controls

1. charge-out
2. trained
3. planned
4. outguide
5. chart-tracking

EXERCISE 7-6 Loose Filing

1. "Loose filing" is individual ancillary and transcribed reports received by the health information department after the patient's discharge from the facility. It is time-consuming to file "loose reports" in discharged patient records.
2. **Filing on Night Shift**

   Advantages:
   - Increased access to medical records because fewer staff are on duty (and there is less competition for access to records)
   - Clerks can perform additional functions (e.g., retrieving records for patient care and incomplete records for physicians)
   - Telephone rings much less during night shift, allowing file clerks to continuously file records (and spend extended time in archived records area if necessary)

   Disadvantages:
   - When filing is completed during just one shift, all of the reports may not be filed in a timely manner
   - Night-shift staff may resent what they perceive to be an increased level of work when compared with requirements of day-shift staff

   Using a Point Person

   Advantages:
   - Organizes reports according to type of patient care, expediting filing function
   - Allows for quick retrieval of loose reports, if needed

   Disadvantages:
   - Filing one type of patient care loose reports before the other results in filing delay

Cutting Steps	Advantages:	• Filing loose reports in a plastic sleeve is faster than inserting them in the record • Reports filed last are more easily retrieved because they are located in the plastic sleeve
	Disadvantages:	• When a record is retrieved, the reports must be inserted in the proper location • When records are prepared for microfilming, reports must be inserted in the proper location
Taking a Shift	Advantages:	• Loose filing remains current • Analysts rotate filing function, providing them with relief from task during "off weeks"
	Disadvantages:	• Inconsistent staff performing loose filing function can result in higher filing error rate • If an analyst consistently does not finish all loose filing during the required week, a burden is placed on other analysts (leading to possible resentment)

EXERCISE 7-7 Circulation Systems

1. F
2. T
3. T
4. F
5. T

EXERCISE 7-8 Security of Health Information

1. F
2. F
3. F
4. T
5. T

CHAPTER REVIEW

True/False

1. F
2. T
3. F
4. T
5. T

Fill-In-The-Blank

6. color-coding
7. centralized filing
8. straight numeric filing
9. pseudonumber
10. file folder, envelopes
11. floor
12. sprinklers
13. closed
14. health information staff
15. 18 to 20

Short Answer

16.

1	10-40-99	9	39-83-01	5	14-83-06
3	11-40-98	12	90-17-54	10	39-84-01
11	56-83-06	2	11-39-98	7	23-01-54
6	15-84-06	4	12-40-98	8	24-01-54

17.

12	10-40-99	1	39-83-01	3	14-83-06
10	11-40-98	8	90-17-54	2	39-84-01
4	56-83-06	9	11-39-98	6	23-01-54
5	15-84-06	11	12-40-98	7	24-01-54

18.

6	10-40-99	9	39-83-01	8	14-83-06
7	11-40-98	3	90-17-54	12	39-84-01
10	56-83-06	4	11-39-98	1	23-01-54
11	15-84-06	5	12-40-98	2	24-01-54

19. a. S-536
    Rationale: "S" is the first letter of the last name; therefore, do not assign a number to it. Assign 5 to the "n," 3 to the "d," and 6 to the "r." Even though consonants "s" and "n" remain, do not assign numbers to them because S-536 is the complete code. (Do not assign numbers to vowels or the letters "w, h, y.")
    b. F-425
    Rationale: "F" is the first letter of the last name; therefore, do not assign a number to it. Assign 4 to the "l," 2 to the "s," and 5 to the "m." (Do not assign numbers to vowels or the letters "letters "w, h, y.")
    c. K-200
    Rationale: "K" is the first letter of the last name; therefore, do not assign a number to it. Do not assign numbers to "c" or "z" because they are key letters or equivalents that occur together (next to the "K"), which are represented by the "K" in the code. Assign 2 to the "sk" because just one code number is assigned when two or more key letters or their equivalents occur together. Assign two 0's to complete the code because you've run out of consonants to which to assign numbers. (Do not assign numbers to vowels or the letters "w, h, y.")
    d. M-445
    Rationale: "M" is the first letter of the last name; therefore, do not assign a number to it. Assign 4 to the first "l." Assign 4 to "ll" because just one code number is assigned when two or more key letters or their equivalents occur together. Assign 5 to the "n." Do not assign a number to "d" because the M-445 code is complete. (Do not assign numbers to vowels or the letters "w, h, y.")

e. D-626
Rationale: "D" is the first letter of the last name; therefore, do not assign a number to it. Assign 6 to "r
Assign 2 to "ss" because just one code number is assigned when two or more key letters or their equiv
alents occur together. Assign 6 to "R." (Do not assign numbers to vowels or the letters "w, h, y.")

20. Outguides are inserted in the space where a record was removed from the file area to indicate that the recor
has been removed and to identify its current location. Periodic audits are completed to ensure that a
records removed from the file area are returned in a timely fashion. They also help ensure that records ar
filed in proper order.

Chapter 8

Indexes, Registers, and Health Data Collection

EXERCISE 8-1 Indexes

1. The purpose of a disease index is to organize patient cases according to ICD-9-CM disease codes so that data and records can be retrieved for study.
2. patient name
3. Procedure index
4. ICD-9-CM and CPT/HCPCS procedure/service codes
5. Advantages and disadvantages to automated and manual MPI systems include:
   - Manual MPI is relatively inexpensive to purchase as compared with automated MPI, which requires initial purchase of computer equipment and software (as well as software upgrades)
   - Automated MPI allows for rapid retrieval of patient information, although a manual MPI allows for access when computer systems are unavailable (e.g., power outage)
   - Manual MPI limits information that can be entered on each card, while automated MPI can be set up to the facility's specifications for data retrieval
   - Automated MPI usually allows for retrieval of patient information according to phonetic filing system (e.g., Soundex), while manual MPI cards can be lost if the patient's information was typed or recorded incorrectly
   - Manual MPI requires retrieval of information within the health information department, while automated MPI can be accessed by authorized personnel outside of the health information department
   - Automated MPI captures patient information upon admission and allows for computer interfacing
6. Admission/discharge/transfer system
7. Computer interface
8. It is important to manage duplicate MPI records when two facilities merge to prevent duplicate patient medical record numbers and patient entries.

EXERCISE 8-2 Registers

1. Centers for Disease Control; National Center for Health Statistics
2. Case report form
3. A register is a collection of information. A registry is a structured system for collecting and maintaining information about a defined population so that analyses and reviews can be performed.
4. The uses of information collected in registries include:
   - Estimating the magnitude of a problem
   - Determining the incidence of disease
   - Examining trends of disease over time
   - Assessing service delivery and identifying groups at high risk
   - Documenting types of patients served by a health provider
   - Conducting research
   - Serving as a source of potential donors
   - Serving as a source of potential participants in clinical trials
5. Registers and registries are secondary sources of patient information. They provide facilities, providers, and public health officials with information needed to assess and monitor the health of a given population.
6. Births, deaths, fetal deaths, marriages, and divorces
7. National Center for Health Statistics
8.

Register/Registry	Sponsor	Description
Adoption Information Registry	State agencies	• Helps adoptees obtain available non-identifying information about birth parents • Enables the reunion of registered adoptees with birth parents and biological siblings • Provides a place for birth parents to file medical information updates that may be shared with registered adoptees
Alzheimer Registry	State agencies	• Collects data to evaluate prevalence of Alzheimer's disease and related disorders • Provides non-identifying information and data for policy planning purposes and to support research
Birth Defects Registry	State agencies	• Maintains statewide surveillance for collecting information on birth defect incidence • Monitors annual trends in birth defect occurrence and mortality • Conducts research studies to identify genetic and environmental risk factors for birth defects • Promotes educational activities for the prevention of birth defects

Register/Registry	Sponsor	Description
Birth Defects Registry or Congenital Anomaly Register (CAR) or Congenital or Congenital Malformations Registry (CMR)	Health care facilities and state agencies	• Repository for case reports on children diagnosed before age two who have suspected or confirmed congenital anomalies, which are structural, functional, or biochemical abnormalities determined genetically or induced during gestation and not due to birthing events • facilities and state agencies identify ICD codes to use for case reporting **NOTE:** Minor anomalies may be excluded from reporting (e.g., inguinal hernias, skin tags, and so on).
Cancer Registry	Health care facilities, groups of health care facilities (that form central registries), and state and federal agencies	• Collects information about all cancers diagnosed (except basal and squamous cell carcinoma of the skin and carcinoma in situ of the cervix, unless required by the registry) • Develops strategies and policies for cancer prevention, treatment, and control • Allows researchers to analyze geographic, ethnic, occupational, and other differences to identify cancer risk factors
Cardiac Registry	Health care facilities	• Captures cardiac surgery information as a research tool for assessing cardiac patient outcomes and pinpointing how patient care can improve
Immunization Registries	Federal and state agencies, such as the National Committee on Health and Vital Statistics (NCHVS), the statutory public advisory body to the Secretary of HHS	• Computerized systems that consolidate vaccination histories as provided by individual health care providers
Implant Registries (or Medical Devices Registries)	Various organizations, depending on type of implant (e.g., National Breast Implant Registry, National Joint Registry, and so on)	• Understand successful implants and assess failures through retrieval analysis • Improve patient care through improvement of implants • Monitor device performance in vivo (inside the body) to permit early corrective therapy **NOTE:** Medical implant devices have a minimum life span of three months, penetrate and have a physiologic interaction with living tissue, and can be retrieved.

Register/Registry	Sponsor	Description
Inpatient Discharge Data Base	State and federal agencies	• Contains hospital inpatient discharge data • Collected to study patterns and trends in the availability, use, and charges for inpatient services • Consists of core data elements, as defined by state and federal agencies (e.g., Uniform Hospital Discharge Data Set, UHDDS)
Insulin-Dependent Diabetes Mellitus Registries	National Institutes of Health (NIH)	• Determine incidence of IDDM in defined populations • Identify persons for subsequent enrollment in case-control studies and other research projects
Metropolitan Atlanta Congenital Defects Program	Centers for Disease Control and Prevention (CDC)	• Monitors occurrence of serious malformations in Atlanta metropolitan area • Tracks changes in trends and unusual patterns that may suggest avoidable risk factors • maintain a case registry for epidemiologic and genetic studies
National Exposure Registry	CDC Agency for Toxic Substances and Disease Registries (ATSDR)	• Identifies, enrolls, and monitors persons who may have been exposed to a hazardous environmental substance
National Registry of Cardiopulmonary Resuscitation (NRCPR)	Sponsored by American Hospital Association, and managed by Tri-Analytics, Inc.	• Collects and analyzes in-hospital resuscitation data • Allows health care facilities to evaluate equipment, resources, and training, and improve practices
National Registry of Myocardial Infarction (NRMI)	Sponsored by Genentech, Inc.	• Examines trends in treatment, length of hospital stay, mortality, and variations among specific patient populations
Organ (or Tissue) Donor Registry	Organizations (e.g., The Living Bank), State agencies	• Computerized database that documents an individual's plan to be an organ donor **NOTE:** Donors should inform family and friends of organ donor plans because enrollment cards and signing the reverse of driver licenses are not legally-binding documents.
Rare Disease Registries (e.g., Li-Fraumeni Syndrome International Registry, Bloom's Syndrome Registry, and so on)	National Organization for Rare Disorders	• Collects clinical and genetic data • Provide referrals to genetic counseling and other services • Conduct ongoing research
Surveillance, Epidemiology, and End Results (SEER) Program	National Cancer Institute (NCI)	• Collects cancer data on a routine basis from designated population-based cancer registries in nine areas of the United States
National Trauma Data Bank	American College of	• Improves quality of patient care

Register/Registry	Sponsor	Description
	Surgeons (ACoS)	• Provides established information system for evaluation of injury care and preparedness • Develops injury scoring and outcome measures • Provides data for clinical benchmarking, process improvement, and patient safety
United States Eye Injury Registry (USEIR)	Helen Keller Eye Research Foundation	• Provides prospective, population-based, epidemiologic data to improve the prevention and control of eye injuries
Vital Records (births, deaths, fetal deaths, divorces, and marriages)	Health care facilities, and county and state agencies	• Record of births, deaths, fetal deaths, induced abortions, teen pregnancies, teen suicides • Files certificates for births, deaths, divorces, and marriages • Collects mortality (death), fetal death (e.g., weight of 350 grams or more or, if weight is unknown, of 20 completed weeks gestation or more), natality (birth) data, and prepares reports • Distributes certificates to eligible persons (e.g., in NYS, birth certificates are distributed to person named on birth certificate; parent of person named on birth certificate—requesting parent's name must be on birth certificate; spouse; child; or other persons by order of a New York State Court) **NOTE:** No birth or death certificate is issued for induced abortions. Fetal death definition varies state to state.

EXERCISE 8-3 Case Abstracting

1. Case abstracting is an automated or manual process performed by health information department staff to collect patient information to determine prospective payment system status, to generate indexes, and to report data to quality improvement organizations and state and federal agencies.
2. Case abstracting allows for collection of data to generate reports and statistics for case mix analysis.
3. The advantages of an automated system include:
   - Calculation of PPS reimbursement
   - Rapid input of case abstract data
   - Storage of case abstracts
   - Output of case abstract statistics (e.g., data entry errors)
   - Generation of reports and statistics for case mix analysis
   - Generation of special reports according to user-defined criteria
   - Submission of mandatory reporting data to state and federal agencies

The disadvantages of an automated system include:
- Cost of initial software/hardware purchase
- Cost of annual licenses
- Maintenance requirements for software (e.g., software updates)
- Training can be costly and complicated
- Site license limits data entry capability (e.g., if just one site license, only one staff member can enter data)

The advantages of a manual system include:
- Less costly
- No "downtime" (as associated with computer system)
- Training is fast and straightforward
- Multiple staff members can abstract at the same time

The disadvantages of a manual system include:
- Use of a paper-based form, which is time-consuming to complete
- Forms must be batched and mailed to vendor
- Report generation is completed by vendor, according to its schedule
- May require additional costs to generate special reports according to user-defined criteria

4. Batched case abstracts contain groups of paper-based abstract forms (e.g., 50) that are sent to a vendor for processing (e.g., keyboard, scanning, and so on).
5. A data set is a standard method for collecting and reporting individual data elements.

Data Set	Health Care Setting	Purpose
Data Elements for Emergency Department Systems (DEEDS)	Providers responsible for maintaining record systems in 24-hour, hospital-based emergency departments (EDs) throughout the United States (participation is voluntary)	• Develops uniform data element specifications for describing single emergency department (ED) patient encounters • Maintained by Centers for Disease Control and Prevention (CDC)
Essential Medical Data Set (EMDS) (pronounced E-MEDS)	Health care facilities that provide emergency services (participation is voluntary)	• Facilitates exchange of critical past medical history information among health care providers • Improves management of critical health care information in ED settings by identifying, defining, and standardizing data elements • Complements DEEDS • Formerly known as the Essential Emergency Data Set (EEDS) • Maintained by the National Information Infrastructure Health Information Network Program (NII-HIN), sponsored by the Defense Advanced Research Projects Agency of the United States government
Health Plan Employer Data and Information Set (HEDIS®)	Managed care organizations (MCOs) (participation is voluntary)	• Standardized performance measures used to compare performance of managed health care plans

Data Set	Health Care Setting	Purpose
		• Maintained by National Committee for Quality Assurance (NCQA)
Minimum Data Set (MDS)	Long-term care facilities (LTCFs) (participation is mandatory for LTCFs that participate in Medicare and Medicaid)	• Core set of screening elements for comprehensive assessment of LTCF residents; used to create resident assessment protocols (RAPs) • Resident Assessment and Validation and Entry (RAVEN) data entry system is used • Standardizes communication about resident problems and conditions • Facilitates quality monitoring and improvement • Maintained by CMS
National Cancer Data Base (NCDB)	Acute care facility (hospital) cancer registries (participation is required for cancer registries accredited by the American College of Surgeon's Commission on Cancer, ACoS COC)	• Nationwide oncology (study of cancer) outcomes database • Assesses patterns of care and outcomes relative to national norms • Maintained by American College of Surgeons ACoS)
Outcome and Assessment Information Set (OASIS)	Home health agencies (HHAs) (participation is mandatory for HHAs that participate in Medicare and Medicaid)	• Core set of comprehensive assessment for adult home care patients • Home Assessment and Validation and Entry (HAVEN) data entry software is used • Measures patient outcomes for outcome-based quality improvement (OBQI) • Patient assessment and care planning, and internal HHAperformance improvement • Agency-level case mix reports that contain aggregate statistics on various patient characteristics such as demographic, health, or functional status at start of care • Maintained by CMS
The Joint Commission ORYX® Initiative	The Joint Commission accredited health care facilities (participation is required of facilities accredited by The Joint Commission)	• Program developed by The Joint Commission that integrates outcomes and other performance measurement data into the accreditation process • Requires accredited facilities to track and submit clinical performance measures as part of the accreditation process

Data Set	Health Care Setting	Purpose
		• Two measurement sets include core performance measures (specific indicators related to disease or process of care; e.g., acute myocardial infarction, or AMI) and non-core measures (general indicators; e.g., mortality rate for AMI patients) • maintained by The Joint Commission
Uniform Ambulatory Care Data Set (UACDS)	Ambulatory care facilities (ACFs) (participation is mandatory for ACFs that participate in Medicare and Medicaid)	• Standard data set for ambulatory health records • Goal is to improve data comparison for ambulatory and outpatient care settings • Maintained by CMS
Uniform Clinical Data Set (UCDS)	Quality Improvement Organizations (QIOs) (participation is mandatory for hospitals that participate in Medicare and Medicaid)	• HCFA (now called CMS) initiative that involves collection of approximately 1,800 data elements that describe patient demographic characteristics, clinical history, clinical findings, and therapeutic intervention • Data is obtained from medical records of Medicare beneficiaries • Maintained by CMS
Uniform Hospital Discharge Data Set (UHDDS)	Acute care facilities (hospitals) (participation is mandatory for hospitals that participate in Medicare and Medicaid)	• Sponsored by National Center for Health Statistics (NCHS) • Standard for collecting data for the Medicare and Medicaid programs • Maintained by CMS

6. The Medical Information Bureau is a clearinghouse of medical and avocation information about people who apply for insurance. The National Practitioner Data Bank contains information about practitioners who engage in unprofessional behavior, and it restricts the ability of incompetent practitioners from moving to another state without disclosure or discovery of previous medical malpractice payment and adverse action history.

EXERCISE 8-4 Health Data Collection

Short Answer

1. Descriptive statistics summarize a set of data using charts, graphs, and tables.
2. General data quality characteristics include data integrity, data reliability, and data validity. Data has integrity if it is accurate, complete, consistent, up-to-date, and the same no matter where the data is recorded. Data is reliable if it is consistent throughout all systems in which it is stored, processed, and retrieved. Data is valid if it conforms to an expected range of values.
3. Four areas of data quality management defined by AHIMA include data application (purpose for which the data are collected), data collection (processes by which data elements are accumulated), data warehousing

(processes and systems used to archive data and data journals), and data analysis (process of translating data into information utilized for an application).

4. Continuous quality improvement (CQI) plays a role in data quality for the organization because it is "an approach to quality management that builds upon traditional quality assurance methods by emphasizing the organization and systems: focuses on 'process' rather than the individual; recognizes both internal and external 'customers'; promotes the need for objective data to analyze and improve processes." (Graham)
5. Ensuring data quality requires the following: data accessibility (ease with which data can be obtained), data accuracy (data that are error free and correct), data comprehensiveness (all required data elements are present in the patient record), data consistency (reliability of data regardless of the way in which data are stored, displayed, or processed), data definition (data elements should have defined meanings and values so all present and future users understand the data), data granularity (each attribute and value of data is defined at the correct level of detail), data precision (yields accurate data collection by defining expected data values), data relevancy (data that is valuable for the performance of a process or activity), and data timeliness (or data currency) (data must be collected and available to the user within a reasonable amount of time and up-to-date).
6. All hospitals compile statistics regarding admission (e.g., daily census count), discharge (e.g., death rate), and length of stay of patients (e.g., average length of stay), which are used to analyze and monitor operations.

CHAPTER REVIEW

Multiple Choice

1. b
2. b
3. a
4. a
5. a
6. a
7. d
8. c
9. d
10. b
11. a
12. a
13. c
14. d
15. d

Matching I

16. c
17. a
18. b

Matching II

19. b
20. c
21. d
22. a

Matching III

23. b
24. c
25. a

Chapter 9

Legal Aspects of Health Information Management

EXERCISE 9-1 Legal and Regulatory Terms

1. T
2. F
3. F
4. F
5. F

EXERCISE 9-2 Maintaining the Patient Record in the Normal Course of Business

1. hearsay, Uniform Business Records
2. electronic
3. transmission
4. state laws
5. Safeguards for records:
   - Created by a person within the business who has knowledge of the acts, conditions, diagnoses, events, or opinions documented
   - Documented in the normal course of business
   - Generated at or near the time of patient care
   - Maintained in the regular course of business

Additional safeguards include:

- Using a computer that is accepted as standard and efficient equipment
- Documenting the method of operation used to create an electronic medical record
- Documenting the method and circumstances of preparing the record includes sources of information on which the record is based
- Implementing procedures for entering information into and retrieving information from the computer, controls and checks used, and tests performed to ensure the accuracy and reliability of the record
- Ensuring that information documented in the EMR has not been altered in any way
- Maintaining records at an off-site backup storage system in case the on-site system is damaged or destroyed
- Using an imaging system to copy documents that contain signatures, ensuring that records, once in electronic form, cannot be altered
- Safeguarding the confidentiality of records and preventing access by unauthorized persons
- Allowing authentication of record entries via electronic signature keys, and implementing procedures for system maintenance

EXERCISE 9-3 Confidentiality of Information and HIPAA Privacy and Security Provisions

1. F
2. T
3. F
4. T
5. F

EXERCISE 9-4 Legislation that Impacts Health Information Management

1. Drug Abuse and Treatment Act of 1972
2. Health Care Quality Improvement Act of 1986
3. Omnibus Budget Reconciliation Act of 1987
4. Healthcare Integrity and Protection Data Bank
5. Health Insurance Portability and Accountability Act of 1996

EXERCISE 9-5 Release of Protected Health Information

1. Miss Molly should first determine how the patient is being transported to Pathway Drug and Alcohol Rehabilitation Center. If the patient is being transported by New Directions Medical Center, a copy of the report should be placed in a sealed envelope and given to the staff member accompanying the patient to the Pathway Drug and Alcohol Rehabilitation Center. The staff member should hand over the report to the registration clerk at the Pathway Drug and Alcohol Rehabilitation Center; the report will be placed in the patient record created at that facility. If the patient is transported privately to Pathway Drug and Alcohol Rehabilitation Center, HIPAA provisions allow for release of the report. Faxing the report in this situation is appropriate because the Pathway Drug and Alcohol Rehabilitation Center needs access to that information to develop a treatment plan for the patient (even though this situation is not an emergency). *Note:* Most health care facilities continue to obtain patient authorization to release protected health information (PHI) even though HIPAA provisions clearly state that release of PHI to a treating provider is permitted so continuity of care can be facilitated.

2. Ms. Marie should use the "call-back method" to respond to this request, which involves obtaining the requesting provider's main switchboard number from the phonebook or directory assistance, calling that number, and asking to be connected to the department (or provider) requesting the PHI to ensure that she is speaking with an individual authorized to obtain the information. *Note:* Most health care facilities continue to obtain patient authorization to release protected health information (PHI) even though HIPAA provisions clearly state that release of PHI to a treating provider is permitted so continuity of care can be facilitated. In no circumstances should Ms. Marie contact the patient's family. This would be considered a breach of confidentiality and illegal under HIPAA provisions.
3. Pam should not respond to the patient via email because this form of communication is not secure. (Emails are not usually encrypted.) Pam should arrange to have the provider call the patient with the lab results.

CHAPTER REVIEW

True/False

1. T
2. F
3. F
4. T
5. T

Multiple Choice

6. b
7. c
8. b
9. d
10. b

Fill-In-The-Blank

11. protected health information
12. privileged communication
13. breach of confidentiality
14. paper-based, verbal
15. patient consent

Short Answer

16. Civil monetary penalties include $100 per violation, up to $25,000 per person/per year for each requirement or prohibition violated. Federal criminal penalties include up to $50,000 and one year in prison for obtaining or disclosing protected health information, up to $100,000 and up to five years in prison for obtaining protected health information under "false pretenses," and up to $250,000 and up to 10 years in prison for obtaining or disclosing protected health information with the intent to sell, transfer, or use it for commercial advantage, personal gain, or malicious harm.
17. Administrative law includes regulations created by administrative agencies of government. Case law is based on judicial decisions and precedent rather than on statutes. Statutory law is passed by a legislative body, and it can be amended, repealed, or expanded by the legislative body.

18. For records to be admissible the records must be:
    - Created by a person within the business who has knowledge of the acts, conditions, diagnoses, events, or opinions documented
    - Documented in the normal course of business
    - Generated at or near the time of patient care
    - Maintained in the regular course of business
19. Protected health information is information that is identifiable to an individual, such as name, address, telephone numbers, social security number, diagnosis, medical record number, and information contained in a patient's record.
20. Covered entities should establish administrative, physical, and technical safeguards.

Administrative Safeguards	Implementation Specifications for Covered Entities
Security management process	Policies and procedures to prevent, detect, contain, and correct security violations include: • *Risk analysis* (assess potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic PHI) • *Risk management* (implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level) • *Sanction policy* (apply appropriate penalties against workforce members who fail to comply with the security policies and procedures of the covered entity) • *Information system activity review* (implement procedures to regularly review records of information system activity, such as audit logs, access reports, and security incident tracking reports)
Assigned security responsibility	Identify the security official responsible for development and implementation of security policies and procedures.
Workforce security	Ensure that all workforce members have appropriate access to electronic PHI, and prevent those workforce members who do not have access from obtaining access to electronic PHI: • *Authorization and supervision* of workforce members who work with electronic PHI or in locations where PHI might be accessed • *Workforce clearance* to determine that the access of a workforce member to electronic PHI is appropriate • *Terminating access* to electronic PHI when the employment of a workforce member ends
Information access management	Authorizing access to electronic PHI: • *Isolating health care clearinghouse functions* if a health care clearinghouse is part of a larger organization; the clearinghouse must implement policies and procedures that protect electronic PHI of the clearinghouse from unauthorized access by the larger organization • *Authorizing access* to electronic PHI (e.g., workstation) • *Establishing and modifying access* to a workstation, transaction, program, or process

Administrative Safeguards	Implementation Specifications for Covered Entities
Security awareness and training	Security awareness and training program for all workforce members: • *Security reminders* via periodic security updates and protection from malicious software to guard against, detect, and report malicious software • *Log-in monitoring* to investigate log-in attempts and report discrepancies • *Password management* to create, change, and safeguard passwords
Security incident procedures	Address security incidents through *response and reporting:* • *Identify and respond* to suspected or known security incidents • *Mitigate,* to the extent practicable, harmful effects of security incidents that are known to the covered entity • *Document* security incidents and their outcomes
Contingency plan	Respond to an emergency or other occurrence (e.g., fire, vandalism, system failure, and natural disaster) that damages systems containing electronic PHI: • *Data backup plan* to create and maintain retrievable exact copies of electronic PHI • *Disaster recovery plan* to restore any loss of data • *Emergency mode operation plan* to enable continuation of critical business processes for protection of the security of electronic PHI while operating in emergency mode • *Testing and revision procedures* for periodic testing and revision of contingency plans • *Applications and data criticality analysis* to assess the relative criticality of specific applications and data in support of other contingency plan components
Evaluation	Perform periodic technical and nontechnical evaluations, based initially upon the standards implemented under this rule, and, subsequently, in response to environmental or operational changes affecting the security of electronic PHI, which establishes the extent to which an entity's security policies and procedures meet security requirements.
Associate contracts and other arrangements	Permit a business associate to create, receive, maintain, or transmit electronic PHI on the covered entity's behalf *only* if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

Physical Safeguards	Implementation Specifications for Covered Entities
Facility access controls	Limit physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed: • *Contingency operations* to allow facility access in support of restoration of lost data under the disaster recovery plan and emergency mode operations plan in the event of an emergency

Physical Safeguards	Implementation Specifications for Covered Entities
	• *Facility security plan* to safeguard the facility and the equipment therein from unauthorized physical access, tampering, and theft • *Access control and validation procedures* to control and validate a person's access to facilities based on their role or function, including visitor control and control of access to software programs for testing and revision • *Maintenance records* to document repairs and modifications to the physical components of a facility that are related to security (e.g., hardware, walls, doors, and locks)
Workstation use	Specify proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surroundings of a specific workstation or class of workstation that can access electronic PHI.
Workstation security	Physical safeguards for all workstations that access electronic PHI to restrict access to authorized users.
Device and media controls	Govern the receipt and removal of hardware and electronic media that contain electronic PHI into and out of a facility, and the movement of these items within the facility: • *Disposal* of electronic PHI and the hardware or electronic media on which it is stored • *Media re-use* to remove electronic PHI from electronic media before the media are made available for re-use • *Accountability* to maintain a record of the movements of hardware and electronic media and any person responsible therefore • *Data backup and storage* to create a retrievable, exact copy of electronic PHI, when needed, before relocating equipment

Technical Safeguards	Implementation Specifications for Covered Entities
Access control	Maintain electronic PHI to allow access only to those persons or software programs that have been granted access rights: • *Unique user identification* to assign a unique name and number for identifying and tracking user identity • *Emergency access procedure* to obtain necessary electronic PHI during an emergency • *Automatic logoff* electronic procedures that terminate an electronic session after a predetermined time of inactivity • *Encryption and decryption* mechanism to encrypt and decrypt electronic PHI
Audit controls	Hardware, software, and procedural mechanisms that record and examine activity in information systems that contain or use electronic PHI.
Integrity	Protect electronic PHI from improper alteration or destruction: • *Mechanism to authenticate electronic PHI* to corroborate that information has not been altered or destroyed in an unauthorized manner

Technical Safeguards	Implementation Specifications for Covered Entities
Person or entity authentication Transmission security	Verify that a person or entity seeking access to electronic PHI is the one claimed. Technical security measures to guard against unauthorized access to electronic PHI that is being transmitted over an electronic communications network: • *Integrity controls* to ensure that electronically transmitted electronic PHI is not improperly modified without detection until disposed of. • *Encryption mechanism* to encrypt electronic PHI whenever deemed appropriate
Business associate contracts or other arrangements	Contracts or other arrangements between the covered entity and its business associate must meet HIPAA requirements.
Requirements for group health plans	Ensure that its plan documents provide that the plan sponsor will reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the plan sponsor on behalf of the group health plan.
Policies and procedures	Comply with the standards, implementation specifications, or other requirements of the security rule.
Documentation	Comply in written (which may be electronic) form; and if an action, activity, or assessment is required to be documented, maintain a written (which may be electronic) record of the action, activity, or assessment: • *Time limit* to retain required documentation is for six years from the date of its creation or the date when it last was in effect, whichever is later • *Availability*—documentation must be made available to those persons responsible for implementing the procedures to which the documentation pertains • *Updates*—documentation must be reviewed periodically and updated as needed in response to environmental or operational changes affecting the security of the electronic PHI

Chapter 10

Coding and Reimbursement

EXERCISE 10-1 Nomenclatures and Classification Systems

Fill-In-The-Blank

1. nonstandard, clearinghouse
2. London Bills of Mortality
3. Systematized Nomenclature of Pathology
4. American Psychiatric Association
5. Current Procedural Terminology

True/False

6. F
7. T
8. T
9. F
10. T

EXERCISE 10-2 Third-Party Payers

1. T
2. F
3. T

4. F
5. T
6. T
7. T
8. F
9. T
10. F

EXERCISE 10-3 Health Care Reimbursement Systems

True/False

1. T
2. T
3. F
4. F
5. T
6. F
7. F
8. F
9. F
10. T

Fill-In-The-Blank

11. physician services
12. outpatient prospective payment system
13. clinical pathways
14. revenue cycle
15. national employer identifier

CHAPTER REVIEW

Multiple Choice

1. d
2. c
3. c
4. d
5. d

True/False

6. T
7. F
8. F
9. T
10. T

Fill-In-The-Blank

11. claims administration, utilization review
12. Medicare
13. CHAMPUS
14. State Children's Health
15. claims administration
16. subscribers
17. self-insurance
18. PACE programs
19. Workers' Compensation
20. Indian Health Service
21. unnecessary cost
22. fraud
23. national electronic standards
24. pre-established
25. retrospective
26. civilian employees
27. copay
28. deductible
29. Health Maintenance Organization Assistance Act of 1973
30. cost outlier

Short Answer

31. Medical nomenclature refers to a vocabulary of clinical and medical terms. A coding system organizes a medical nomenclature according to similar conditions, diseases, procedures, and services and establishes codes for each.
32. The purpose of standard coding guidelines is to simplify claims submission for health care providers who deal with multiple third-party payers and to improve data quality.
33. Public domain means that the information contained in a publication is not copyrighted.
34. ICD-10 has 8,000 categories, uses 3-digit alphanumeric category codes, and is published in three volumes.
35. The Systematized Nomenclature of Medicine codifies all activities within the patient record, including medical diagnoses and procedures, nursing diagnoses and procedures, patient signs and symptoms, occupational history, and the many causes and etiologies of diseases.

36. Prior to implementation of major government-sponsored health programs (e.g., Medicare, Medicaid, etc.) beginning in 1965, health care services were reimbursed as follows:
    - Blue Cross and Blue Shield (private and group health plans)
    - Commercial health insurance (private)
    - Employer-based group health insurance and self-insurance plans
    - Government-sponsored programs, limited to the following: Indian Health Service (limited eligibility), Dependents medical care program (health care for dependents of active military personnel)
    - Prepaid health plans (forerunner of managed care)
    - Self-pay (patients paid cash)
    - Workers' Compensation (limited eligibility)
37. Prospective payment systems (PPS) preestablish reimbursement rates for health care services. Retrospective payment systems allowed hospitals to bill third-party payers after health care services were provided to the patient.
38. A chargemaster lists all the procedures, services, and supplies provided to patients by a hospital; charges for each may also appear.
39. HIPAA national identifiers include the following:
    - National employer identifier—IRS's federal tax employer identification number (EIN) was adopted as the national employer identifier, retaining the hyphen after the first two numbers (e.g., 12-3456789).
    - National provider identifier (NPI)—Hospitals, doctors, nursing homes, and other health care providers to obtain a unique identifier consisting of 10 numeric digits for filing electronic claims with public and private insurance programs.
    - National health plan identifier (PlanID)—Assigned to third-party payers and contains 10 numeric positions including a check digit in the 10th position (e.g., 1234567890).
    - Personal identifier—This HIPAA requirement has been withdrawn.
40. Local coverage determinations specify under what clinical circumstances a service is covered (including under what clinical circumstances it is considered to be reasonable and necessary) and correctly coded. They assist providers (e.g., facilities, physicians, and suppliers) in submitting correct claims for payment. LCDs outline how contractors (e.g., Medicare carriers) will review claims to ensure that they meet Medicare coverage requirements.

Section III

Chapter Quizzes

CHAPTER 1 QUIZ

1. Health care delivery in the United States has been greatly impacted by escalating costs, resulting in medical necessity requirements (to justify acute care hospitalizations), review of appropriateness of admissions, and requirement for administration of quality and effective treatments. Which was implemented as a direct result of current health care delivery methods?
   a. Health care consumers demand higher-quality, more costly health care, and the focus is on primary and preventive care.
   b. Patients routinely undergo preadmission testing on an outpatient basis instead of being admitted as a hospital inpatient.
   c. Tertiary-care level services provided by specialized hospitals equipped with diagnostic and treatment facilities are offered in all communities.
   d. The performance of outpatient testing and surgical procedures has decreased due to advances in technology.
2. As the United States population increased, there was a corresponding need for health care facilities and trained personnel. Which was an impact of this need?
   a. Health care delivery in the twentieth century emphasized decreased costs.
   b. Standards for hospitals and the training of medical personnel were developed.
   c. The increase in schools and hospitals ensured high-quality health care.
   d. There was a decline in the need for health care insurance.
3. The National Medical Association was created in 1895 to represent
   a. African-American physicians and health professionals in the United States.
   b. hospital administrators.
   c. hospitals and health care networks.
   d. physicians who adopted a "whole person" approach to providing health care.

4. The Food and Drug Administration was originally called the Bureau of Chemistry, and serves the func-tion of
   a. conducting disease research.
   b. monitoring the purity of foods and the safety of medicines.
   c. performing on-site inspections of hospitals.
   d. providing medical services to migrant and seasonal farm workers and their families.
5. In 1910, the Carnegie Foundation for the Advancement of Teaching issued the Flexner Report, which stated that
   a. more than 180,000 General Electric employees had been provided with health care insurance.
   b. more than 3,200 hospitals achieved approval under the Hospital Standardization Program.
   c. only 89 of 692 hospitals surveyed met requirements of the American College of Surgeons' Minimum Standard for Hospitals.
   d. only one of the 155 medical schools in the United States and Canada at that time provided an acceptable medical education.
6. The original purpose of The Joint Commission was to
   a. improve services in nursing homes.
   b. provide voluntary accreditation to hospitals.
   c. qualify health care facilities for Medicare reimbursement.
   d. strengthen the utilization review process.
7. The "end result system of hospital standardization" was developed in 1910 by Ernest Codman, MD. Standardization was intended to:
   a. improve the quality of care for surgical patients by establishing standards for surgical education and practice.
   b. modernize hospitals that had become obsolete due to lack of capital investment throughout the period of the Great Depression and World War II.
   c. provide federal employees with hospitalization and surgical benefits.
   d. track patients long enough to determine whether treatment was effective; if treatment was ineffective, hospitals would attempt to determine why so that similar cases could be treated successfully in the future.
8. In 1929, the first Blue Cross plan was offered at Baylor University in Dallas, Texas, to guarantee
   a. grants to states to provide various forms of medical care.
   b. health care services to Pacific Northwest lumber and mining camps at the turn of the century.
   c. private health insurance coverage for hospital care in dozens of states.
   d. schoolteachers 21 days of hospital care for $6 a year.
9. The Hill-Burton Act was passed to provide federal grants to modernize hospitals that had become obsolete due to lack of capital investment throughout the period of the Great Depression and World War II (1929 to 1945). In return for federal funds, facilities agreed to
   a. construct nursing homes and establish of voluntary health planning agencies at local levels.
   b. establishing criteria for the discharge and transfer of Medicare and Medicaid emergency patients.
   c. improve the health of people who live in communities without access to primary health care (or primary care).
   d. provide free or reduced charge medical services to persons unable to pay.
10. When an accreditation organization is granted "deemed status," this means that
    a. accredited health care facilities have met or exceeded "Conditions of Participation" to participate in the Medicare and Medicaid programs.
    b. health care facilities are no longer required to participate in Quality Improvement Organization (QIO) initiatives.
    c. hospitals and other health care facilities are granted lifetime accreditation status.
    d. reimbursement is based on per diem rates, not prospective payment system rates.

11. Ultimate legal authority and responsibility for the hospital's operation is the responsibility of the
    a. administration.
    b. department chairpersons.
    c. governing board.
    d. medical staff.

12. Medicaid is a health care program for
    a. infants, children, and teens.
    b. people age 65 or older, with disabilities, and diagnosed with End-Stage Renal Disease.
    c. people who need prescription drug coverage.
    d. some people with low incomes and limited resources.

13. In 2002, the Centers for Medicare & Medicaid Services announced that peer review organizations (PROs) would be known as quality improvement organizations (QIOs), and they will continue to
    a. establish statewide utilization and quality control peer review organizations.
    b. maintain hundreds of independent peer review organizations to monitor the appropriateness, quality, and outcome of the services to Medicare beneficiaries.
    c. perform quality control and utilization review of health care furnished to Medicare beneficiaries.
    d. reimburse acute care hospitals' predetermined rates according to discharge diagnoses.

14. The Emergency Medical Treatment and Labor Act (EMTALA) is called the "antidumping statute" be-cause it
    a. addressed the problem of hospitals failing to screen, treat, or appropriately transfer patients by establishing criteria for the discharge and transfer of Medicare and Medicaid patients.
    b. established a data bank of information about practitioners' credentials, including previous medical malpractice payment and adverse action history.
    c. required that consumers be provided with informed consent information about their right to make advance health care decisions.
    d. required the reporting of cases of substandard care to licensing and certification agencies.

15. An internist sees a patient with an unusual blood condition and then refers the patient to a specialist. This is an example of
    a. continuity of care.
    b. primary care.
    c. secondary care.
    d. tertiary care.

16. Privately owned health care facilities distribute excess income to shareholders and are categorized as
    a. for-profit.
    b. government.
    c. not-for-profit.
    d. voluntary.

17. Public hospitals are categorized as
    a. not-for-profit.
    b. for-profit.
    c. proprietary.
    d. teaching.

18. Many of the physicians in a teaching hospital are interns and residents who work under the supervision of senior staff physicians. A resident has
    a. a medical degree and is continuing training immediately following completion of the four-year medical curriculum.
    b. been granted active medical staff status by the health care facility.
    c. completed an internship and is engaged in a program of advanced, specialized training.
    d. not yet written the state licensing exam to become a physician (e.g., MD).

19. Which staff undergo an appointment procedure to be granted clinical privileges by the hospital governing board, which delegates authority and responsibility to maintain proper standards of medical care and to provide well-defined patient care services?
    a. department personnel
    b. hospital administrators
    c. house officers
    d. medical staff
20. Medical staff policies that delineate medical staff responsibilities are called
    a. bylaws.
    b. procedures.
    c. regulations.
    d. rules.
21. Coders assign ICD-9-CM procedure codes to which of the following cases?
    a. emergency room
    b. inpatient
    c. outpatient
    d. physician office
22. The purpose of abstracting patient cases is to
    a. classify diagnoses and procedures for facilities.
    b. generate statistical reports and disease/procedure indexes.
    c. identify deficiencies in the discharged patient record.
    d. process reimbursement for inpatient and outpatient care.
23. If a facility adopts the universal chart order, this means that
    a. after a patient is discharged from the health care facility, the record is assembled in chronological date order.
    b. discharged patient reports are maintained in chronological date order to eliminate the patient record assembly task.
    c. inpatient reports are filed in strict chronological date order within each section of the patient record.
    d. the discharged patient record is organized in the same order as when the patient was on the nursing floor.
24. State laws require health care facilities to obtain
    a. accreditation.
    b. deeming authority.
    c. licensure.
    d. regulation.
25. Which are regulations that interpret laws?
    a. Centers for Medicare & Medicaid Services (CMS)
    b. Code of Federal Regulations (CFR)
    c. Conditions of Participation (CoP)
    d. Federal Register

ANSWER KEY TO CHAPTER 1 QUIZ

1. b
2. b
3. a
4. b
5. d

6. b
7. d
8. d
9. d
10. a
11. c
12. d
13. c
14. a
15. a
16. a
17. a
18. c
19. d
20. a
21. b
22. b
23. d
24. c
25. c

CHAPTER 2 QUIZ

1. Cancer registrars collect cancer data from a variety of sources and report cancer statistics to government and health care agencies. The primary responsibility of the cancer registrar is to
   a. assign code numbers to all diagnoses, services, and procedures, based on patient record documentation.
   b. ensure the timely, accurate, and complete collection and maintenance of cancer data.
   c. organize, analyze, and maintain patient information to ensure the delivery of quality health care.
   d. review health-related claims to determine whether the costs are reasonable and medically necessary, based on the patient's diagnosis.
2. A coding specialist ensures that all diagnoses, services, and procedures documented in patient records are coded accurately to
   a. ensure the delivery of quality health care.
   b. determine whether the costs are reasonable and medically necessary, based on the patient's diagnosis.
   c. ensure reimbursement, and for research and statistical purposes.
   d. plan, direct, coordinate, and supervise the delivery of health care.
3. Patient data is organized, analyzed, and maintained by health information managers to
   a. ensure the delivery of quality health care.
   b. ensure the timely, accurate, and complete collection and maintenance of cancer data.
   c. plan, direct, coordinate, and supervise the delivery of health care.
   d. verify claims against third-party payer guidelines.

4. Health insurance specialists verify health claims against third-party payer guidelines to
   a. authorize appropriate payment or refer the claim to an investigator for a more thorough review.
   b. determine whether the costs are reasonable and medically necessary, based on the patient's diagnosis.
   c. ensure reimbursement, and for research and statistical purposes.
   d. ensure the delivery of quality health care.
5. Health services managers plan, direct, coordinate, and supervise the delivery of health care. They include specialists who
   a. complete physician credentialing procedures.
   b. coordinate a health care facility's quality improvement program.
   c. direct clinical departments or services.
   d. perform routine administrative and clinical tasks.
6. Medical assistants perform routine administrative and clinical tasks, which include
   a. answering telephones, greeting patients, and arranging outpatient laboratory tests.
   b. ensuring the timely, accurate, and complete collection and maintenance of cancer data.
   c. examining, diagnosing, and treating patients under the direct supervision of a physician.
   d. managing the physician credentialing process.
7. Medical staff coordinators usually report directly to the health care facility's administrator, and they are responsible for managing the medical staff office and complying with medical staff bylaws, which means they manage the
   a. physician credentialing and recredentialing process.
   b. privacy of patient health information.
   c. professional and general liability incidents, claims, and lawsuits.
   d. quality improvement program.
8. A privacy officer oversees the development, implementation, and maintenance of, and adherence to, an organization's policies and procedures covering privacy of and access to patient health information in compliance with
   a. federal and state laws.
   b. federal laws only.
   c. state laws only.
   d. federal laws, regardless of whether state laws supercede federal laws.
9. A quality manager coordinates a health care facility's quality improvement program to
   a. analyze actual and potential risks to the health care facility.
   b. conduct accreditation surveys.
   c. identify liability incidents, claims, and lawsuits.
   d. improve patient outcomes.
10. A risk manager investigates incident reports to
    a. ensure they are filed in the patient record.
    b. prepare patients for testimony against the facility.
    c. provide copies to the plaintiff's attorney.
    d. recommend appropriate corrective action.
11. The hospital's quality management department has determined that 10% of the medical staff is noncompliant regarding documentation issues related to appropriate assignment of diagnosis and procedure codes. Which professional would be best to provide in-service training in this area?
    a. cancer registrar
    b. coding specialist
    c. medical staff coordinator
    d. quality manager

12. Mrs. Petrie enters the physician's office for her appointment and signs in at the reception area. Which professional initially greets Mrs. Petrie and updates her registration information in the computer system?
    a. coding specialist
    b. health insurance specialist
    c. health services manager
    d. medical assistant
13. Mr. Lambert was seen in the office two months ago. He returns today because his insurance company has denied payment of that claim. Which professional would review Mr. Lambert's claim to verify it against third-party payer guidelines to determine if payment is authorized?
    a. coding specialist
    b. health insurance specialist
    c. health services manager
    d. utilization manager

ANSWER KEY TO CHAPTER 2 QUIZ

1. b
2. c
3. a
4. a
5. c
6. a
7. a
8. a
9. d
10. d
11. b
12. d
13. b

CHAPTER 3 QUIZ

1. Diagnosis-related groups (DRGs) classify inpatient hospital cases into groups that are expected to consume similar hospital resources. Which is characteristic of inpatient care received under DRGs?
    a. Inpatients are always transferred from the hospital to another inpatient care setting.
    b. Inpatients are discharged from the hospital once their acute phase of illness has resolved.
    c. Inpatients remain in the hospital until they are well enough to be discharged home.
    d. Transfer facilities that accept hospital inpatients typically provide high-cost care.
2. An acute care facility (ACF) is a hospital that provides health care services to patients who have serious, sudden, or acute illnesses or injuries and who need certain surgeries. Which is an accurate statement about an ACF?
    a. A quality manager closely monitors patient care for medical necessity.
    b. Inpatient stays are typically lengthy (more than 30 days).
    c. Services are limited to emergency and critical care.
    d. They provide a full range of health care services.

3. Hospitals have an organized medical and professional staff, and inpatient beds are available 24 hours per day. The primary function of hospitals is to provide inpatient medical and nursing services
   a. along with other services (e.g., outpatient).
   b. exclusively as single hospitals, where the facility is not part of a larger organization.
   c. to non-surgical patients, along with other services (e.g., outpatient).
   d. to surgical and non-surgical patients, but no other services.
4. A consideration when discussing hospital organization is to identify the "population served by a health care facility." This means that health care is provided to specific groups of people. Which is a true statement?
   a. A facility that specializes in the treatment of inpatient children is usually called a pediatric hospital.
   b. Facilities that serve as "mini-intensive care units" are called emergency hospitals.
   c. The hospital's longest length of stay (LOS) determines whether the hospital is classified as short- or long-term.
   d. The inpatient bed size licensed by the state determines whether the hospital is general or specialized.
5. To calculate an inpatient length of stay (LOS), count the day of admission but not the day of discharge. A patient admitted on July 25 and discharged on August 3 has which LOS?
   a. 7 days
   b. 8 days
   c. 9 days
   d. 10 days
6. Hospitals categorized as critical access hospitals (CAH) are
   a. allowed to maintain no more than 15 inpatient beds.
   b. encouraged to provide emergency services 24 hours per day.
   c. federally certified as being a necessary provider of health care to area residents.
   d. located more than 35 miles from any hospital or another CAH.
7. Which is characteristic of general hospitals?
   a. They admit patients who are diagnosed with trauma or disease and need to learn how to function.
   b. They specialize in treatment of individuals with mental health diagnoses.
   c. They concentrate on a particular population of patients or disease.
   d. They provide emergency care, perform general surgery, and admit patients for a range of problems from fractures to heart disease, based on licensing by the state.
8. Physicians who spend most of their time in a hospital setting admitting patients to their inpatient services from local primary care providers are called
   a. attending physicians.
   b. hospitalists.
   c. internists.
   d. residents.
9. Outpatients are treated and released the same day and do not stay overnight in the hospital. Their length of stay (LOS) is a maximum of
   a. 11 hours, 59 minutes, and 59 seconds.
   b. 23 hours, 59 minutes, and 59 seconds.
   c. 24 hours, 00 minutes, and 00 seconds.
   d. 24 hours, 59 minutes, and 59 seconds.
10. Ambulatory surgery patients undergo certain procedures that can be performed on an outpatient basis, which means the patient is
    a. considered an inpatient.
    b. receiving sub-acute care.
    c. treated and released the same day.
    d. treated for urgent problems.

11. Which is an example of durable medical equipment (DME) that patients would use in their home?
    a. daily living activities
    b. home infusion care
    c. inpatient bed
    d. wheelchair

12. Hospice care provides comprehensive medical and supportive social, emotional, and spiritual care to terminally ill patients and their families. The goal of hospice is to provide
    a. long-term care.
    b. palliative care.
    c. respite care.
    d. therapeutic care.

13. Measurement of the ability of health care facilities to deliver care that is safe and adequate in accordance with federal law and regulation is called federal
    a. accreditation.
    b. certification.
    c. licensure.
    d. regulation.

14. A long-term care hospital (LTCH) is defined in the Medicare law as a hospital that has an average inpatient length of stay (LOS) that is:
    a. an average of 25 days.
    b. exactly 25 days.
    c. greater than 25 days.
    d. less than 25 days.

15. Long-term care services that provide assistance with activities of daily living (ADL) are associated with
    a. custodial care.
    b. intermediate care.
    c. managed care.
    d. skilled care.

16. Medicare does not usually reimburse
    a. home health care services.
    b. hospice care services.
    c. residential care facility services.
    d. skilled care facility services.

17. Preadmission certification (PAC) is defined as a form of utilization management that
    a. controls health care costs by reviewing cases for appropriateness.
    b. includes a review of patient cases to determine that quality health care is provided.
    c. involves the review for medical necessity of inpatient care prior to inpatient admission.
    d. requires the documentation of services needed for diagnosis or treatment of a medical condition.

18. Which managed care model provides benefits to subscribers who receive health care services from network providers?
    a. Exclusive Provider Organization (EPO)
    b. Independent Practice Association (IPA)
    c. Integrated Delivery System (IDS)
    d. Management Service Organization (MSO)

19. Physicians who are employed by a health maintenance organization (HMO) are members of a
    a. direct contract model HMO.
    b. group model HMO.
    c. network model HMO.
    d. staff model HMO.
20. Independent practice associations negotiate a health maintenance organization contract that manages the predetermined "capitation payment," which is the
    a. fixed amount a subscriber must pay when seeking health care services.
    b. lump sum paid by the HMO to care for a group of subscribers.
    c. monthly payment the subscriber sends to the HMO for health care services.
    d. percentage of costs paid by the patient for health care services provided by the HMO.
21. "Major medical care" is provided to inmates by a
    a. Bureau of Prisons (BOP) institution.
    b. correctional facility.
    c. federal medical center (FMC).
    d. prison clinic.
22. The Military Health System (MHS) administers health care for active members of the uniformed services (and their dependents). Which provides health care services?
    a. Military Medical Support Office (MMSO)
    b. military treatment facilities and networks of civilian health care professionals
    c. Public Health Service (PHS) Commission Corps
    d. Veterans Health Administration (VHA)

ANSWER KEY TO CHAPTER 3 QUIZ

1. b
2. d
3. a
4. a
5. c
6. d
7. d
8. b
9. b
10. c
11. d
12. b
13. b
14. c
15. a
16. c
17. c
18. a

19. d
20. b
21. c
22. b

CHAPTER 4 QUIZ

1. Which is the goal of both manual and electronic patient records?
   a. documentation of patient care
   b. medicolegal protection of providers
   c. reimbursement of health care services provided
   d. research and education
2. Which is most important for medicolegal purposes?
   a. discharge summary
   b. entire record
   c. nurses notes
   d. progress notes
3. Although hospital inpatient records have traditionally served as the documentation source and business record for patient care information,
   a. all patient records contain similar content and format features.
   b. alternate care facility records serve as the best documentation source for patient care information.
   c. patient identification information must be captured by the physician's office that treats the patient.
   d. the definition and purpose of the patient record is supported only by the financial record.
4. Information capture is the process of recording representations of human thought, perceptions, or actions in documenting patient care, as well as device-generated information that is gathered or computed about a patient as part of health care. Which is an example of information capture?
   a. analyzing patient information
   b. constructing a health care document (paper or digital)
   c. formatting or structuring captured information
   d. generating images through X-rays
5. The primary purpose of the patient record is to provide *continuity of care*, which means
   a. documenting services so others have a source from which to base care.
   b. evaluating the quality of patient care.
   c. providing information to third-party payers for reimbursement.
   d. serving the medicolegal interests of the patient, facility, and providers of care.
6. Which of the following statements is accurate?
   a. The medical record is the property of both provider and patient.
   b. The medical record is the property of the provider.
   c. The patient owns the documents in the medical record.
   d. The provider owns the information in the medical record.
7. Mrs. Wright is a long-standing patient of Dr. Bartron's medical practice. Mrs. Wright also happens to be a credentialed health information professional, and she comes to the physician's office today to request access to her medical record. She wants to make sure that the recent history that was documented by Dr. Bartron accurately reflects statements about her recent car accident. The receptionist has Mrs. Wright sign an authorization to release information and arranges to supervise Mrs. Wright's review of the record. Upon review, Mrs. Wright determines that there is an error in the documentation and she approaches the medical

assistant to request that it be corrected. How should the medical assistant (MA) respond? The MA informs Mrs. Wright that
a. because the receptionist shouldn't have let Mrs. Wright review the record in the first place, her request for correction is denied.
b. Dr. Bartron does not correct entries in the medical record, but Mrs. Wright can write a letter clarifying the information, which will be filed in the record.
c. medical record entries can be corrected only after Mrs. Wright submits a letter that clarifies the information that she wants changed.
d. she has the right to access its contents for review and to request that the physician amend the record to correct inaccurate information.

8. The hospital inpatient record documents the care and treatment received by a patient admitted to the hospital. Where is the paper-based record stored while the patient is in the hospital?
a. All patient records are stored in the health information department.
b. Each record is housed in the location specified in the physician's order.
c. The inpatient record is typically located at the nursing station.
d. The record is placed in a locking wall desk at the nursing unit.

9. Since the early 1980s, provision of outpatient services has steadily increased due to cost savings associated with providing health care on an ambulatory instead of an inpatient basis. This shift from inpatient to outpatient care has also resulted in hospital health information departments managing a(n)
a. decreasing volume of outpatient information.
b. equal volume of inpatient and outpatient information.
c. fluctuating volume of outpatient information.
d. increasing volume of outpatient information.

10. Patient health care services received in a physician's office are documented in the physician office record, which includes both administrative and clinical data. Generally, physicians who practice independently use a(n) _____ used by physicians in a group practice.
a. less structured office record versus a more structured office record
b. more structured office record versus a less structured office record
c. office record that is very similar in comparison to the hospital inpatient record
d. structured office record similar to that

11. One of the statements below is an interpretation of the familiar phrase, "if it wasn't documented, it wasn't done" in the following case: Dr. White performed a thyroid biopsy procedure at the patient's bedside. He didn't document it in the patient's record. Which statement is correct?
a. The health care facility should reprimand Dr. White and possibly suspend his privileges.
b. The patient has no legal recourse to bring a malpractice suit against the physician.
c. The physician is not allowed to add documentation of the procedure to the record after the fact.
d. Upon review of the record, the third-party payer can refuse to pay for the procedure.

12. Health care services rendered *must* be documented to prove that care was provided and that good medical care is supported by patient record documentation. Therefore, inadequate patient record documentation may indicate
a. an illegible entry should be rewritten by its author.
b. enhanced continuity of care.
c. poor health care delivery.
d. the need to adopt an auto-authentication policy.

13. A countersignature is a form of authentication by an individual in addition to the signature by the original author of an entry. It is mandated by
    a. CMS regulations.
    b. federal statute.
    c. The Joint Commission standard.
    d. state law.
14. A telephone order (T.O.) is a verbal order taken over the telephone by a qualified professional from a physician. Which statement below is correct as related to a T.O.?
    a. A federal statute mandates that a voice order (V.O.) can no longer be documented.
    b. Documenting a T.O. should be reserved for emergency situations when the physician is unavailable.
    c. Facilities usually require a T.O. to be authenticated within 48 hours of documentation.
    d. The attending physician countersigns any T.O. in accordance with state regulations.
15. Rubber stamp signatures can be accepted by facilities if allowed by state and federal law. When rubber stamp signatures are authorized for use in a facility, a provider whose signature the rubber stamp represents must sign a statement that
    a. he or she alone will use the stamp to authenticate documents.
    b. indicates an understanding of the state and federal mandates related to signature stamps.
    c. is maintained on file in the provider's office.
    d. specifies who has permission to use the stamp to authenticate documents.
16. Plans to learn more about the patient's condition and the management of the conditions is known as the:
    a. diagnostic/management plan
    b. therapeutic plans
    c. patient education plans
    d. admission plans
17. The Joint Commission requires patient records to be completed 30 days after patient discharge, at which time they become delinquent records. Calculate the delinquent record rate for the following case: As of July 31, 150 total delinquent records were on file. The facility discharged 725 patients during July. The delinquent record rate for July is
    a. 17%.
    b. 21%.
    c. 26%.
    d. 483%.
18. Dr. Broad dictated a discharge summary on July 15, which was transcribed and placed in the patient record later the next day. Upon review of the report, Dr. Broad decided not to authenticate it and re-dictated it. He told the medical transcriptionist the reason was that, when he originally dictated the report, he had been ill with the flu; the report is incomplete and doesn't flow properly. Dr. Broad drew one line across each page of the report, wrote "Re-dictated" on it, and dated and signed the notation. After the transcriptionist transcribes the new dictation, what action should the file clerk take? The file clerk should
    a. insert the newly transcribed report after the old report.
    b. place the newly transcribed report on top of the old report.
    c. remove the original report from the record and insert the newly transcribed report.
    d. use a permanent marker to redact the old report, and file the new report.

19. A technical control mechanism created by an electronic health record system that consists of a listing of all transactions and activities that occurred, along with date, time, and user who performed the transaction, is called a(n)
    a. addendum.
    b. amended record.
    c. audit trail.
    d. indexed record.
20. Preadmission testing (PAT) incorporates patient registration, testing, and other services into one visit prior to
    a. ancillary care.
    b. emergency care.
    c. inpatient care.
    d. urgent care.
21. X-ray films are considered a _____ of patient information.
    a. primary source
    b. secondary source
22. The original patient record is a _____ of information.
    a. primary source
    b. secondary source
23. EKGs are a _____ of patient information.
    a. primary source
    b. secondary source
24. Indexes and registers are a _____ of patient information.
    a. primary source
    b. secondary source
25. An incident report is a _____ of patient information.
    a. primary source
    b. secondary source
26. The inpatient record format that is organized according to sections is called the
    a. electronic record.
    b. integrated record.
    c. problem oriented record.
    d. source oriented record.
27. In what order is the source oriented record usually arranged for permanent filing purposes?
    a. by sections, chronological date order
    b. by sections, reverse chronological date order
    c. in the problem oriented fashion
    d. integrated, reverse chronological date order
28. The problem oriented record's database
    a. acts as a table of contents for the patient record because it is filed at the beginning of the record and contains a list of the patient's problems.
    b. contains minimum information collected on every patient, such as chief complaint, present conditions and diagnoses, social data, etc.
    c. describes actions that will be taken to learn more about the patient's condition and to treat and educate the patient.
    d. includes one or more problems and notes documented for each using a subjective, objective, assessment, and plan structure.

29. The problem oriented record's problem list
    a. acts as a table of contents for the patient record because it is filed at the beginning of the record and contains a list of the patient's problems.
    b. contains minimum information collected on every patient, such as chief complaint, present conditions and diagnoses, social data, etc.
    c. describes actions that will be taken to learn more about the patient's condition and to treat and educate the patient.
    d. includes one or more problems and notes documented for each using a subjective, objective, assessment, and plan structure.
30. The problem oriented record's initial plan
    a. acts as a table of contents for the patient record because it is filed at the beginning of the record and contains a list of the patient's problems.
    b. contains minimum information collected on every patient, such as chief complaint, present conditions and diagnoses, social data, etc.
    c. describes actions that will be taken to learn more about the patient's condition and to treat and educate the patient.
    d. includes one or more problems and notes documented for each using a subjective, objective, assessment, and plan structure.
31. The problem oriented record's progress notes
    a. act as a table of contents for the patient record because they are filed at the beginning of the record and contain a list of the patient's problems.
    b. contain minimum information collected on every patient, such as chief complaint, present conditions and diagnoses, social data, etc.
    c. describe actions that will be taken to learn more about the patient's condition and to treat and educate the patient.
    d. include one or more problems and notes documented for each using a subjective, objective, assessment, and plan structure.
32. SOAP is the abbreviation for
    a. Source, Objective, Assessment, Problem.
    b. Subjective, Objective, Analysis, Plan.
    c. Subjective, Objective, Assessment, Plan.
    d. Subjective, Objective, Assessment, Problem.
33. The SOAP format is commonly used by physicians to document progress notes; the subjective portion is the
    a. documentation of patient physical examination.
    b. patient's problem in his or her own words.
    c. physician orders for treatment of the patient.
    d. physician's terminology that describes the patient's problem.
34. The COmputer STored Ambulatory Record (COSTAR) System is a(n)
    a. collection of patient information documented by a number of providers at different facilities regarding one patient.
    b. outpatient electronic health record created at Massachusetts General Hospital with the goal of improving the availability and organization of outpatient records.
    c. product created using vendor software, which also assists in provider decision making.
    d. alternative to traditional microfilm or remote storage systems because patient records are converted to an electronic image and saved on storage media.

35. HIPAA requires government insurance claims to be retained for a period of no less than _____ years.
    a. 6
    b. 10
    c. 18
    d. 30
36. Which would be performed as part of quantitative analysis?
    a. abstracting information from the patient record into a computer software program
    b. review of the face sheet and patient record to locate a diagnosis missing from the face sheet
    c. review of the patient record for inconsistent documentation
    d. review of the record to ensure that each document is present and authenticated
37. Qualitative analysis involves the review of the patient record for
    a. inaccurate documentation.
    b. patient identification on each report.
    c. presence of authentication by providers.
    d. reports that are missing.
38. The best way to mark authentication deficiencies in the patient record is to
    a. call each physician and leave a message as to the number of chart deficiencies.
    b. complete a deficiency form and place it in the physician's mailbox.
    c. use a red marking pen to enter a check mark next to documentation that needs authentication.
    d. use pressure-sensitive colored tags to flag missing signatures.

ANSWER KEY TO CHAPTER 4 QUIZ

1. a
2. b
3. a
4. d
5. a
6. b
7. d
8. c
9. d
10. a
11. d
12. c
13. d
14. b
15. a
16. c
17. b
18. b
19. c
20. c

21. a
22. a
23. a
24. b
25. b
26. d
27. a
28. b
29. a
30. c
31. d
32. c
33. b
34. b
35. a
36. d
37. a
38. d

CHAPTER 5 QUIZ

1. From 1970 to 1980, the term _____ was used to describe early attempts at medical record automation.
   a. automated medical record
   b. computerized medical record
   c. patient health record
   d. personal health record
2. Maria Jones's medical record includes records from different episodes of care, providers, and facilities, which are linked to form a view, over time, of her health care encounters. This type of medical record is called a:
   a. comprehensive patient record.
   b. computer-based patient record.
   c. longitudinal patient record.
   d. patient historical record.
3. Which of the following is a DISADVANTAGE of manual medical records?
   a. low start-up costs
   b. record linkage
   c. simplified staff training
   d. timely capture of information
4. The electronic or paper-based medical record that is maintained and updated by an individual for personal use is called a
   a. patient health record
   b. patient medical record
   c. personal health record
   d. personal medical record

5. Samantha Smith, HIM manager, is transitioning a manual patient record system to an electronic health record system by capturing existing paper record images in an electronic storage media. The most effective approach to accomplish this would be to:
   a. Entirely recreate the manual health information in the electronic health record system.
   b. Exclude manual patient record information from the electronic health record system.
   c. Keyboard all manual patient record system data into the electronic health record system.
   d. Scan existing paper record images using a scanner to create the electronic health record.
6. Disadvantages of automated record systems include all EXCEPT which of the following?
   a. difficulty abstracting information
   b. increased start-up costs
   c. need for technical staff to maintain system
   d. time-consuming staff training
7. The standards development organization that creates electronic health record standards under the direction of the U.S. Department of Health and Human Services is called:
   a. AHIMA
   b. AMA
   c. CMS
   d. HL7
8. Which of the following statements is FALSE?
   a. Electronic health record systems are advantageous because there is no requirement for downtime.
   b. Facilities need to clearly define their legal record so as to respond to various requests for an entire patient record when an electronic health record system is implemented.
   c. Implementation of each electronic health record system is based on information needs, budget, existing automated systems, and other factors unique to the organization.
   d. No two facilities have the same electronic health record system.
9. The use of electronic health records can accomplish all EXCEPT which of the following?
   a. decreased lengths of stay
   b. improved health care quality
   c. reduced health care costs
   d. reduced medical errors
10. Raw facts that are not interpreted or processed, such as numbers, letters, images, symbols, and sounds, are called:
    a. characters
    b. data
    c. fields
    d. information
11. A group of characters forms a(n):
    a. data item
    b. field
    c. information field
    d. record
12. A collection of records is called a:
    a. character set
    b. field
    c. file
    d. information set

13. Which of the following is NOT an administrative application of an electronic health record system?
    a. admission/discharge/transfer and registration
    b. business and financial functions
    c. medication administration record documentation
    d. payroll applications
14. Tom Smith is using an electronic health record system that collects and monitors a patient's vital signs. This is a:
    a. patient clinical system
    b. patient monitoring system
    c. vital signs data system
    d. vital signs information system
15. Joint Commission standards require inpatient hospital records to be completed within _____ days after discharge.
    a. 10
    b. 20
    c. 30
    d. 40
16. The functions of electronic health record (EHR) _____ applications include ordering X-ray tests, creating MRI/CT images, and reporting X-ray test results.
    a. laboratory
    b. nursing
    c. pharmacy
    d. radiological
17. Which of the following statement is TRUE?
    a. A record contains more data than a file.
    b. Information is data that has been given meaning.
    c. Information is raw facts.
    d. The first letter of a person's last name represents a field.
18. The impact of the American Recovery Reinvestment Act (ARRA) on health care technology includes all of the following EXCEPT:
    a. advancement of health information exchange
    b. decreased HIM workforce opportunities
    c. establishment of new privacy regulations
    d. provision of incentives for EHR adoption
19. RHIOs provide all of the following benefits for hospitals EXCEPT:
    a. decrease in administrative costs
    b. improved patient care quality
    c. increased number of laboratory tests
    d. reduction in number of admissions
20. Which of the following is FALSE? When health plans and insurers participate in an RHIO:
    a. Administrative costs increase.
    b. Coordination of patient care is facilitated.
    c. Physicians have rapid access to patient information.
    d. Public health issues are monitored through use of aggregate data increases.

ANSWER KEY TO CHAPTER 5 QUIZ

1. b
2. c
3. d
4. c
5. d
6. a
7. d
8. a
9. a
10. a
11. b
12. c
13. c
14. b
15. c
16. d
17. b
18. b
19. c
20. a

CHAPTER 6 QUIZ

1. A discharge summary is required for all
   a. ambulatory surgery cases.
   b. inpatient hospitalizations greater than 48 hours for uncomplicated cases.
   c. inpatient hospitalizations regardless of length of stay.
   d. normal newborn and obstetrical cases.
2. If a physician documents a complete H&P in the office, it is acceptable to place a durable/legible copy on the inpatient record if it was documented within _____ days prior to admission.
   a. 30
   b. 48
   c. 72
   d. 60
3. Operative reports are to be documented _____ after surgery.
   a. immediately
   b. within 24 hours
4. A pathology report is required
   a. at the discretion of the pathologist.
   b. at the discretion of the surgeon.
   c. only in predefined cases when tissue is removed.
   d. whenever tissue (or other material) is removed.

5. A provisional diagnosis is also known as a
   a. comorbidity.
   b. final diagnosis.
   c. principal diagnosis.
   d. tentative diagnosis.
6. The tissue report is the written report of findings on surgical specimens and is documented by the
   a. attending physician.
   b. pathologist.
   c. radiologist.
   d. surgeon.
7. Major sections of the history include
   a. family and past history, mental and neuropsychiatric exams, personal exams, and physical exams.
   b. past history, family history, social history, review of systems, impression, and lab data.
   c. past history, social history, chief complaint, present illness, and review of systems.
   d. social and family history, past history, present illness, physical exam, and system review.
8. A graphic record documents
   a. the amount of medicine given per dose.
   b. the number of times a patient is visited by his doctor.
   c. the total number of times a patient has been in the hospital.
   d. vital signs throughout the patient's stay.
9. Who provides the patient's admitting diagnosis for an inpatient stay?
   a. admitting office
   b. admitting physician
   c. attending physician
   d. emergency department
10. An operative record should contain a
    a. description of the procedure.
    b. history of anesthesia reactions.
    c. post-anesthesia status.
    d. vital signs.
11. The history of present illness
    a. describes the patient's current illness.
    b. is a review of symptoms by body system.
    c. is a statement about the patient's life.
    d. summarizes the patient's past illnesses.
12. Where is the fact that a patient smokes cigarettes documented?
    a. family history
    b. physical examination
    c. review of systems
    d. social history
13. Laboratory tests are ordered by the
    a. laboratory technician.
    b. medical technologist.
    c. pathologist.
    d. responsible physician.

14. An "impression" is most likely to be found on the
    a. advanced directive.
    b. discharge summary.
    c. face sheet.
    d. physical exam.
15. The review of systems is found on the
    a. history.
    b. physical examination.
16. A patient is admitted on May 1 and discharged on May 2. The diagnosis is tonsillectomy, and the patient underwent routine tonsillectomy. Which applies?
    a. A discharge note must be documented in the progress notes.
    b. A discharge summary must be dictated.
    c. A short stay record may be documented.
    d. An interval history and physical can be documented.
17. If the physician wants to determine how her patient reacted to a new medication administered during the night, she would review the
    a. ancillary data.
    b. medication administration record.
    c. nurses notes.
    d. physician orders.
18. Inpatient progress notes are documented
    a. according to federal government mandates.
    b. as the patient's condition warrants.
    c. at least on a daily basis.
    d. more than once a day, as a minimum.
19. The face sheet is also known as admission/discharge
    a. record.
    b. register.
20. The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care is the _____ diagnosis.
    a. principal
    b. principle
21. Which type of inpatient procedure is usually sequenced first?
    a. diagnostic procedure to treat a complication
    b. diagnostic procedure to treat the reason for admission after study
    c. therapeutic procedure to treat a complication
    d. therapeutic procedure to treat the reason for admission after study
22. The Joint Commission standards specify that a history and physical must be completed within the first _____ of patient admission to the hospital.
    a. 24 hours
    b. 48 hours
    c. 72 hours
    d. 10 days
23. A coexisting condition is a
    a. comorbidity.
    b. complication.

24. The best method of communication for members of the health care team caring for a hospital inpatient is the
    a. consultation report.
    b. discharge summary.
    c. physician orders.
    d. progress notes.
25. An interval history can be documented on a readmitted patient if the readmission is
    a. for the same or similar condition.
    b. within 60 days of previous admission.
26. The description of surgical tissue analysis is found on the
    a. autopsy report.
    b. laboratory report.
    c. operative report.
    d. pathology report.
27. The choice of anesthesia to be administered during surgery is documented by the anesthesiologist on the
    a. operative record.
    b. pre-anesthesia evaluation note.
    c. preoperative note.
    d. recovery room record.
28. The physician wants to review his patient's previous records to determine an overall picture of the previous treatment provided to the patient. Which report would provide summary information?
    a. clinical resume
    b. history & physical
    c. physician orders
    d. progress notes
29. Progress notes are a chronological report of the patient's hospital course and reflect changes in the patient's condition and response to treatment, providing
    a. data entries that direct patient treatment during an inpatient stay.
    b. documentation of patient examination and review of the patient record.
    c. evidence that sufficient treatment was rendered to justify the stay.
    d. the only basis upon which the patient or payer is billed for the hospital stay.
30. Which is an ancillary service form?
    a. flow sheet
    b. laboratory report
    c. medical administration record
    d. nursing discharge summary
31. Which statement would be documented in the physical examination?
    a. admitted because of sharp epigastric pain
    b. had cholecystectomy three years ago
    c. HEAD: occasional headache
    d. negative bowel sounds

ANSWER KEY TO CHAPTER 6 QUIZ

1. b
2. a
3. a

4. d
5. d
6. b
7. c
8. d
9. b
10. a
11. a
12. d
13. d
14. d
15. a
16. c
17. c
18. b
19. a
20. a
21. d
22. a
23. a
24. d
25. a
26. d
27. b
28. a
29. c
30. b
31. d

CHAPTER 7 QUIZ

1. Which filing system houses all patient records in one department?
   a. centralized
   b. decentralized
2. Terminal-digit filing is also called reverse numerical filing because
   a. deceased patient records are filed according to this system.
   b. the last two numbers of the patient number are considered primary.
3. When a patient is assigned a new number at each admission to the hospital and a separate record is generated for the patient, which numbering system is being utilized?
   a. phonetic
   b. serial
   c. serial-unit
   d. unit

4. Which system is used when a patient receives a number on his first admission and retains that number for all subsequent admissions?
   a. phonetic
   b. serial
   c. serial-unit
   d. unit
5. When filing patient number 38-47-23 according to terminal digit, the digits "23" would be considered
   a. primary.
   b. pincipal.
   c. secondary.
   d. tertiary.
6. Within one primary section, which represents records filed in terminal digit order?
   a. 00-00-52, 01-00-52, 02-00-52, 03-00-52
   b. 00-00-52, 01-00-53, 02-00-54, 03-00-55
   c. 00-00-52, 01-40-53, 02-40-54, 03-35-55
   d. 05-00-52, 02-00-53, 01-00-54, 06-00-54
7. Six patients were admitted to the hospital between 9:00 and 10:00 a.m. on January 1. The following patient numbers were entered, one after another, in the admission register: 9010, 2053, 9011, 9012, 3155, 0381. Which numbering system does the hospital use?
   a. pseudonumbering
   b. serial
   c. serial-unit
   d. unit
8. How does the serial-unit system differ from the serial system?
   a. Serial-unit records on the same patient are filed in one location in the health information department files, while serial records on the same patient are filed in multiple locations.
   b. There is no difference; both the serial and serial-unit filing systems follow the same number assignment guidelines as well as filing procedures in the filing system.
9. The file area requires 2,000 file guides. Which pattern of guides will appear in the terminal-digit files?
   a. 00 00 00, 00 05 00, 00 10 00
   b. 00 00 00, 00 00 50, 00 01 00
   c. 00 00 00, 00 50 00, 01 00 00
   d. 00 00 00, 00 00 05, 00 00 10
10. An outguide is typically used within the health record filing system to
    a. identify convenient units of patient record folders.
    b. indicate that a patient record has been removed.
    c. separate files by departments.
    d. show that a record has been lost.
11. Loose filing usually involves
    a. filing reports in the record that are generated after a patient is discharged.
    b. filing reports that have been previously misplaced.
    c. leaving space available in a file system to allow additional records to be filed.
    d. stapling together reports that are loose in a folder.
12. In a terminal-digit filing system, if the number is 64 79 36, the tertiary number is
    a. 36.
    b. 64.
    c. 79.
    d. 936.

13. The hospital assigned patient numbers using the serial numbering system. Which number was most recently assigned by Admissions?
    a. 44 10 74
    b. 56 00 96
    c. 76 02 82
    d. 89 03 76
14. Which numbering system is typically used when a hospital assigns pseudonumbers as patient numbers?
    a. family
    b. serial
    c. serial-unit
    d. unit
15. A jukebox is a component of
    a. automated record tracking.
    b. microfilming.
    c. optical imaging.
    d. transcribing dictation.
16. The medical center has adopted the unit numbering system to assign patient numbers. The number that will be assigned to the next admission is 201562. Patricia Sloan's number on her last admission was 010921. What number is assigned to Miss Sloan today as she is registered for outpatient care?
    a. 010921
    b. 010922
    c. 201562
    d. 201563
17. The primary purpose of color-coding the file system is to
    a. flag deficiencies.
    b. guide files.
    c. indicate missing records.
    d. reduce misfiles.
18. How many secondary sections does each primary section have in terminal-digit filing?
    a. 50
    b. 100
    c. 1000
    d. 10,000
19. Open shelf filing is preferred over file cabinets because
    a. filing is more hazardous.
    b. it is more attractive.
    c. it is required by The Joint Commission.
    d. less floor space is required.
20. Alfred State Medical Center has a total of 20,000 records in their filing system and plans to place a guide every 100 records. How many guides will be needed?
    a. 50
    b. 100
    c. 200
    d. 400

21. Which system requires extra digits in front of (or at the end of) the patient number to signify placement of the individual in the household?
    a. family numbering
    b. pseudonumbering
    c. social security numbering
    d. unit numbering
22. A physician's office currently uses 2,800 linear filing inches to store its records and wishes to purchase new equipment. Each of the new shelves in a 5-shelf unit measures 30 linear filing inches. An additional 850 filing inches should be added to allow for 5-year expansion capabilities. How many shelving units are needed?
    a. 3
    b. 13
    c. 17
    d. 25
23. What type of filing units are mounted on tracks?
    a. lateral files
    b. movable files
    c. open shelf files
    d. visible files
24. Which allows for ease in the expansion of a file folder?
    a. activity legend
    b. color-coding
    c. fasteners
    d. scoring
25. The review of a filing system to locate misfiles is called
    a. auditing.
    b. color-coding.
    c. guiding.
    d. requisitioning.
26. When a record is removed from the filing system, what is left in its place?
    a. file guide
    b. incomplete record
    c. loose file
    d. outguide
27. When the length of time a record remains active has passed, the record is processed for _____.
    a. destruction
    b. filing
    c. retention
    d. storage
28. When using the straight numeric filing methodology, which would be filed first?
    a. 11320
    b. 12465
    c. 62374
    d. 73912

ANSWER KEY TO CHAPTER 7 QUIZ

1. a
2. b
3. b
4. d
5. a
6. a
7. d
8. a
9. a
10. b
11. a
12. b
13. d
14. d
15. c
16. a
17. d
18. b
19. d
20. c
21. a
22. d
23. b
24. d
25. a
26. d
27. a
28. a

CHAPTER 8 QUIZ

1. A formal or official recording of items, names, or actions is called a
   a. register.
   b. registry.
2. An organized system for the collection, storage, retrieval, analysis, and dissemination of information on individuals who have either a particular disease, a condition that predisposes to the occurrence of a health-related event, or prior exposure to substances (or circumstances) known or suspected to cause adverse health effects is called a
   a. register.
   b. registry.

3. Soundex is a phonetic
   a. filing system.
   b. numbering system.
4. Ideally, the master patient index (MPI) is retained by the facility
   a. according to state statute.
   b. as established by medical staff bylaws.
   c. in accordance with federal law.
   d. permanently.
5. The master patient index (MPI) is filed
   a. alphabetically.
   b. chronologically.
   c. numerically.
   d. reverse numerically.
6. Which is the key for locating patient records filed by number?
   a. admission/discharge register
   b. discharge log
   c. master patient index
   d. patient registry
7. If more than one person with the same surname and first name has been admitted to the hospital, the master patient index cards are arranged alphabetically by
   a. date of birth.
   b. date of discharge.
   c. middle name.
   d. patient number.
8. The main advantage of phonetic filing of master patient index cards is
   a. emphasis is placed on foreign languages.
   b. keyboarding errors are eliminated.
   c. names that sound alike are filed together.
   d. spelling accuracy is ensured.
9. Which statement is true about filing master patient index (MPI) cards?
   a. A married woman's MPI card is filed under her husband's first name.
   b. A surname particle, such as "da" in daVinci, is not considered when filing MPI index cards.
   c. Titles that precede an individual's name, such as Doctor or Sister, are considered when filing MPI cards.
   d. When the patient's legal name has an initial first, such as T. Berry Brazelton, the initial is considered when filing and precedes all full first names.
10. Vital statistics are compiled for events, which include births, deaths, fetal deaths, marriages, and divorces. Which federal agency is responsible for maintaining official vital statistics?
    a. Census Bureau
    b. Department of Health and Human Services (DHHS)
    c. National Center for Health Statistics (NCHS)
    d. National Committee on Vital and Health Statistics (NCVHS)
11. An automated or manual process performed by health information department staff to collect patient information to determine prospective payment system (PPS) status, to generate indexes, and to report data to quality improvement organizations and state and federal agencies is called
    a. case abstracting.
    b. case mix analysis.

12. Before the case abstracting process can begin, a standard method for collecting and reporting individual data elements must be established so data can be easily compared. This is called a
    a. data dictionary.
    b. data set.
13. Which is a clearinghouse of medical and avocation information about people who apply for insurance?
    a. Medical Information Bureau (MIB)
    b. National Practitioner Data Bank (NPDB)
14. Which contains information about practitioners who engage in unprofessional behavior? (Its purpose is to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move to another state without disclosure or discovery of previous medical malpractice payment and adverse action history.)
    a. Medical Information Bureau (MIB)
    b. National Practitioner Data Bank (NPDB)
15. Which is an example of descriptive statistics?
    a. narrative report
    b. run chart
16. Data _____ is accurate, complete, consistent, up-to-date, and the same no matter where the data is recorded.
    a. integrity
    b. quality
    c. reliability
    d. validity
17. A technique that uses software to search for patterns and trends and to produce data content relationships is called data
    a. analysis.
    b. collection.
    c. mining.
    d. warehousing.
18. Limited two-dimensional structures that do not allow for complete trend analysis are called
    a. online analytical processing (OLAP) servers.
    b. relational databases.

ANSWER KEY TO CHAPTER 8 QUIZ

1. a
2. b
3. a
4. d
5. a
6. c
7. c
8. c
9. d
10. c
11. a
12. a
13. a

14. b
15. a
16. a
17. c
18. a

CHAPTER 9 QUIZ

1. The date of a patient's authorization to release information is generally accepted
   a. according to established facility policy.
   b. at any time regardless of the date.
   c. as long as it contains an expiration date.
   d. in accordance with federal regulations.
2. Release of information regulations regarding alcohol and drug abuse records
   a. is strictly governed by federal legislation.
   b. varies according to state release of information laws.
   c. is treated the same as release of psychiatric records.
   d. can be accomplished by court order only.
3. Alcohol or drug abuse records may be released via
   a. court order.
   b. *subpoena duces tecum.*
   c. tort.
   d. interrogatory.
4. A *subpoena duces tecum* requires the
   a. completion of a list of written questions by the party served.
   b. deponent to answer certain questions, obtained as a sworn statement.
   c. patient to produce his records in court and testify.
   d. witness to come to court with specified documents.
5. A patient demands to see his medical record. How would you proceed?
   a. Advise him to request records through his attorney.
   b. Advise the patient of the procedure for access to information.
   c. Allow him to view the records immediately because HIPAA requires that you do so.
   d. Tell him that he cannot view his record because the law does not allow it.
6. Mary, a 15-year-old girl who had an appendectomy, lives with both parents, who are married to each other. Life Secure Insurance requested medical information before payment of the claim. The consent form for release of information should be signed by
   a. both parents.
   b. either parent.
   c. Mary.
   d. Mary and either parent.
7. Mildred is transferred from the Alfred State Medical Center to the Regional Trauma Center. The emergency department (E.D.) nurse at the Regional Trauma Center calls to request that a copy of the patient's discharge summary be faxed immediately. What should you do?
   a. Contact the patient to obtain her authorization to release the information.
   b. Fax the discharge summary to the Regional Trauma Center's E.D.
   c. Require patient authorization before faxing the information.
   d. Use the call-back method to verify authenticity for the request for information.

8. Documentation regarding release of patient information to outside agencies is usually kept in the
   a. accession register.
   b. admission/discharge register.
   c. correspondence log.
   d. master patient index.
9. A court order is signed by the
   a. attorney.
   b. court clerk.
   c. judge.
   d. patient.
10. Rule of conduct passed by a legislative body that is enforced by the government and results in penalties when violated is called a
    a. civil law.
    b. contract.
    c. statute.
    d. tort.
11. Which deals with the legal rights and relationships of private individuals and includes torts and contracts?
    a. civil law
    b. criminal law
    c. public law
    d. statutory law
12. Any wrongful act for which a civil suit can be brought is called a(n)
    a. tort.
    b. contract.
    c. deposition.
    d. interrogatory.
13. Which deals with relationships between individuals and government and includes criminal law and regulations?
    a. civil law
    b. criminal law
    c. public law
    d. statutory law
14. Published rules that interpret laws are called
    a. cases
    b. depositions
    c. regulations
    d. torts.
15. The individual who initiates a civil complaint and has the burden of proof is called the
    a. administrator.
    b. attorney.
    c. defendant.
    d. plaintiff.
16. The individual against whom the complaint is brought is called the
    a. attorney.
    b. claimant.
    c. defendant.
    d. plaintiff.

17. Which is the legal process lawyers use to obtain information about all aspects of a case?
    a. deposition
    b. discovery
    c. interrogatory
    d. trial
18. Which is a form of discovery that includes a list of written questions that must be answered by the party upon which it is served?
    a. deposition
    b. discovery
    c. interrogatory
    d. trial
19. Which is a form of discovery used to obtain a sworn statement from a witness?
    a. deposition
    b. discovery
    c. interrogatory
    d. trial
20. Which is based on judicial decisions and precedent rather than on statutes?
    a. administrative law
    b. case law
    c. civil law
    d. public law
21. For HIV-related information requests, an authorization is
    a. not required.
    b. required.
22. For public health activities, an authorization is
    a. not required.
    b. required.
23. For patient or patient representative requests for information, an authorization is
    a. not required.
    b. required.
24. For health care providers who did not render care to the patient, an authorization is
    a. not required.
    b. required.
25. For research purposes, an authorization is
    a. not required.
    b. required.

ANSWER KEY TO CHAPTER 9 QUIZ

1. a
2. b
3. a
4. d
5. b
6. b

7. d
8. c
9. c
10. c
11. a
12. a
13. c
14. c
15. d
16. c
17. b
18. c
19. a
20. b
21. b
22. a
23. b
24. b
25. a

CHAPTER 10 QUIZ

1. A vocabulary of clinical and medical terms is called a
   a. coding system.
   b. medical nomenclature.
2. Which organizes a medical nomenclature according to similar conditions, diseases, procedures, and services and establishes numeric and alphanumeric characters for each?
   a. classification system
   b. medical nomenclature
3. Which is used to report diagnoses?
   a. ABC
   b. CPT
   c. HCPCS
   d. ICD
4. A third-party payer is an organization that
   a. acts on behalf of insurance companies to process insurance claims.
   b. processes claims for reimbursement covered by a health care plan.
5. Which of the following was developed in 1929 by the New York Academy of Medicine as the first medical nomenclature to be universally accepted in the United States?
   a. *Basle Nomina Anatomica*
   b. Standardized Nomenclature of Disease (SND)
   c. Standardized Nomenclature of Diseases and Operations (SNDO)
   d. Systematized Nomenclature of Pathology (SNOP)

6. Payers (except prepaid or managed care plans) initially reimbursed providers according to a fee-for-service system that billed payers after health care services were provided to the patient. This was a _____ payment system.
   a. prospective
   b. retrospective
7. Health care facilities analyze their case mix to
   a. determine whether a facility is serving caseloads that include disproportionate shares of patients with above-average (or below-average) care needs.
   b. forecast health care trends unique to their individual settings, ensure that they continue to provide appropriate services to their patient populations, and recognize that different patients require different resources for care.
8. A case mix adjustment
   a. allows payment systems to decrease the average difference between the pre-established payment and each patient's actual cost to the facility.
   b. always results in reduced risk to facilities and to payers because facilities are willing to admit high-resource cases because higher payments can be anticipated.
   c. creates an incentive for facilities to admit large volumes of low-need low-cost patients, which will result in lower payments.
   d. is the analysis and measurement of standards of patient care to assess quality.
9. Severity of illness is the physiologic complexity that comprises the extent and interactions of a patient's diseases as presented to medical personnel. Severity of illness scores are based on
   a. ICD codes.
   b. physiologic measures and ICD codes.
10. A chargemaster lists
    a. procedures, services, and supplies provided to patients by a hospital; charges for each may also appear.
    b. procedures, services, and supplies provided to patients by a physician; charges may also appear.
11. A CMS-1450 (or UB-04) is a standard institutional claim form submitted by
    a. hospitals, skilled nursing facilities, and other institutional-based providers to payers to obtain reimbursement for health care services provided to patients.
    b. providers of services to obtain reimbursement for professional fees for procedures and services rendered to patients.
12. Revenue codes, which classify categories of service by revenue cost center, are submitted on the
    a. CMS-1450.
    b. CMS-1500.
13. Which was developed during the latter part of the sixteenth century and is considered the first classification system?
    a. Bertillon International Statistical Classification of Causes of Death
    b. International Classification of Diseases, Adapted for Use in the United States (ICDA)
    c. London Bills of Mortality
    d. Nosologia Methodica
14. Which is published as a standard classification of mental disorders used by mental health professionals in the United States?
    a. ABC
    b. DSM
    c. ICD-O-3
    d. ICF

15. Which was originally published by the American Medical Association (AMA) in 1966 and classifies procedures and services?
    a. Current Dental Terminology (CDT)
    b. Current Procedural Terminology (CPT)
    c. Healthcare Common Procedure Coding System (HCPCS) level II
    d. National Drug Codes (NDC)
16. Which provides health care benefits to dependents of veterans who are rated 100% permanently and totally disabled as a result of service-connected conditions, veterans who died as a result of service-connected conditions, and veterans who died on duty with less than 30 days of active service?
    a. Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
    b. Federal Employee Health Benefits Program (FEHBP)
    c. Indian Health Service (IHS)
    d. TRICARE
17. Which is a joint federal and state program that provides health care coverage to low-income populations and certain individuals who are elderly and disabled?
    a. Medicaid
    b. Medicare
    c. Military Health System (MHS)
    d. Programs of All-inclusive Care for the Elderly (PACE)
18. Which is an inpatient prospective payment system (IPPS) that reimburses short-term hospitals predetermined rates for Medicare inpatient services?
    a. ambulatory payment classifications (APCs)
    b. diagnosis-related groups (DRGs)
    c. home health resource groups (HHRGs)
    d. resource utilization groups (RUGs)
19. Which methodology is used to reimburse physician services covered by Medicare Part B?
    a. ambulance fee schedule
    b. ambulatory surgical center (ASC) payments
    c. clinical laboratory fee schedule
    d. resource based relative value scale (RBRVS) system
20. Which of the following is the unique identifier used to file electronic claims with public and private insurance programs?
    a. federal tax employer identification number (EIN)
    b. national health plan identifier (PlanID)
    c. national provider identifier (NPI)
    d. personal identifier
21. Billing Medicare for services or supplies not provided is considered
    a. fraud.
    b. abuse.
22. Entering another person's Medicare number on a claim to obtain reimbursement for a patient who is not eligible for Medicare is considered
    a. fraud.
    b. abuse.
23. Unbundling codes reported on claims is considered
    a. fraud.
    b. abuse.

24. Upcoding claims submitted to payers is considered
    a. fraud.
    b. abuse.
25. Billing Medicare patients using a higher fee schedule rate than that used for non-Medicare patients is considered
    a. fraud.
    b. abuse.
26. Submitting claims to Medicare when Medicare is not the beneficiary's primary payer is considered
    a. fraud.
    b. abuse.
27. Submitting excessive charges for services or supplies or claims for services that aren't medically necessary is considered abuse.
    a. fraud.
    b. abuse.
28. Violating Medicare participation or assignment agreements is considered
    a. fraud.
    b. abuse.
29. Interdisciplinary guidelines developed by hospitals to facilitate management and delivery of quality clinical care in a time of constrained resources are called _____. They allow for the planning of provision of clinical services that have expected time frames and resources targeted to specific diagnoses and/or procedures.
    a. case mix adjustments
    b, chargemasters
    c. compliance guidances
    d. critical pathways
30. The physiologic complexity that comprises the extent and interactions of a patient's disease(s) as presented to medical personnel is called _____.
    a. case mix
    b. electronic data interchange
    c. overpayment recovery
    d. severity of illness

ANSWER KEY TO CHAPTER 10 QUIZ

1. b
2. a
3. d
4. a
5. b
6. b
7. a
8. a
9. a
10. a
11. a
12. a

13. c
14. b
15. b
16. a
17. a
18. b
19. d
20. c
21. a
22. a
23. a
24. a
25. b
26. b
27. b
28. b
29. d
30. d

Section IV

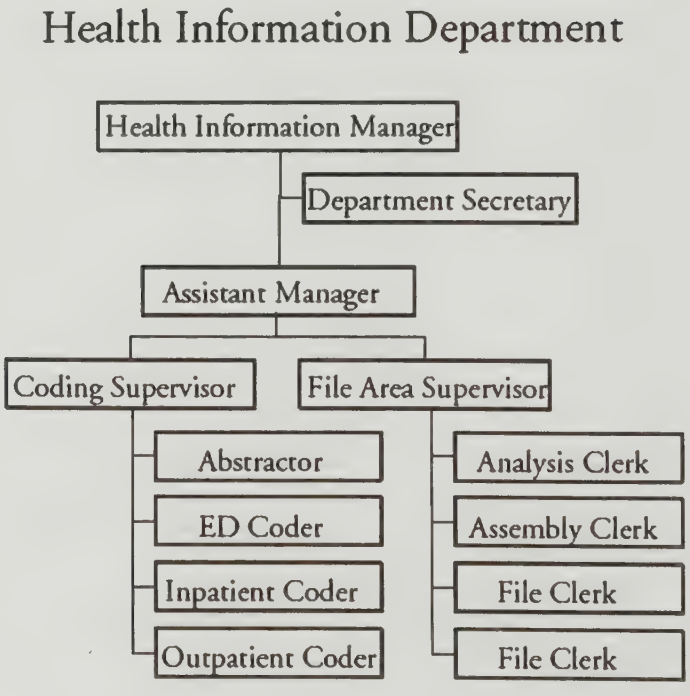
Lab Manual Answer Keys

REMEMBER! The online companion contains resources that are to be used with lab assignments (e.g., patient records).

Chapter 1

Health Care Delivery Systems

LAB ASSIGNMENT 1-1 Organizational Charts



LAB ASSIGNMENT 1-2 Information Literacy

Students will complete TILT modules at http://tilt.lib.utsystem.edu/, and submit quiz results to instructor via email.

Students will also complete an annotated bibliography that contains two citations, using APA style. Evaluate the student's annotated bibliography according to the criteria below; the student was to include four criteria:

- Description of article's content and focus
- Whether the article's content is useful
- Article's limitations (e.g., outdated)
- Audience for which the article is intended
- Evaluation of any research methods used in the article
- Author's background
- Any conclusions the author(s) made about the topic
- Your reaction to the article

LAB ASSIGNMENT 1-3 Committee Minutes

Student will submit the following word-processed documents for evaluation:

- Committee minutes
- Agenda for the next committee meeting

Evaluate the committee minutes to be sure the following elements were included:

- Date, place, and time of the meeting
- Members present
- Members absent
- Guests present
- Items discussed
- Actions taken
- Time meeting adjourned
- Location, time, and date of next meeting
- Closing

Chapter 2

Health Information Management Professionals

LAB ASSIGNMENT 2-1 Interview of a Professional

The student will submit a 2- to 3-page word-processed interview of a professional; the paper should be in paragraph format (not Q&A). Each paragraph should contain a minimum of three sentences, and the student should write in complete sentences. There should also be no typographical or grammatical errors in the paper. The last paragraph of the paper should summarize the student's reaction to the interview and whether the student would be interested in having this professional's position (along with why or why not). Also, the student should predict the future by writing about where she or he will be in 10 years (in terms of employment, family, etc.).

LAB ASSIGNMENT 2-2 Cover Letters and Résumés

The student will submit a résumé and cover letter (similar to the examples in Figures 2-1 and 2-2 of the *Lab Manual*).

NOTE: If the instructor or school teaches a different résumé and cover letter writing style, evaluate based on that style.

LAB ASSIGNMENT 2-3 Professional Discussion Forums (Listserv)

The student will go to http://list.nih.gov/, and click on "WHAT IS LISTERV?" to learn all about online discussion forums (Listservs). The student will also select a professional discussion forum from Table 2-1 in the *Lab Manual* and follow its membership instructions. If this assignment is completed by the student outside of class, the instructor can require students to submit a summary of the experience (or, if teaching online, post a discussion).

LAB ASSIGNMENT 2-4 Professional Code of Ethics

Ethical codes breached in each scenario will vary, depending on which professional code of ethics the student uses to complete the assignment. The students should demonstrate in their responses the type of ethical breach that occurred and how the situation should have been handled.

Professional Code of Ethics Assignment

Case	Type of Ethical Breach	How Situation Should Have Been Handled to Avoid Breach of Ethics
1	Conflict of interest	As professionals, we make no recommendation (good or bad) about colleagues. Chris Professional's neighbor should have been referred to the local hospital's medical staff coordinator, who can provide a list of physicians according to specialty. The neighbor can then make their own selection. (Chris should have told her neighbor that to discuss the competency of professional staff members and physicians is a conflict of interest.)
2	Integrity	Even though Chris Professional did not know she would be receiving a gift prior to her recommendation of the product, it could be considered a kickback from the company. Chris should have respectfully declined the gift. (Another option would be to report the gift to her boss and complete the appropriate paperwork to accept the gift for facility-wide use.) Chris should review facility policy on accepting gifts from vendors to receive more guidance.
3	Patient confidentiality	By displaying a fellow student's records, Chris Professional breached confidentiality of patient information and was non-compliant regarding HIPAA privacy rules. Chris should have taken this opportunity to remind the students that discussing others is unprofessional and, when they are patients, illegal. She should also communicate to the students that such a breach of confidentiality would result in their termination from the professional practice experience (because employees are fired for such behavior).
4	Conflict of interest, patient confidentiality, and security of health records	Chris Professional should have denied the lunch invitation because turning over the record in such circumstances is a breach of confidentiality of patient information. To appropriately comply with the subpoena (*duces tecum*), Chris needed to be sworn in at court so the record could be entered into evidence. She should also have informed the court clerk of the attorney's behavior.
5	High standards for education	Everyone is busy, and if Chris Professional cannot assist this inexperienced woman, she should have been referred to someone who could assist (e.g., state or local health information association office).
6	Confidentiality of patient information	Chris Professional breached confidentiality of patient information by supplying a natural baby food service with the names and addresses of all mothers delivered of living infants in the hospital. By accepting $5.00 per name, she may also have violated federal anti-kickback laws (e.g., Stark legislation).
7	Provide accurate information	Chris Professional should have reported Dr. Monroe's request to her boss. Chris should not have verified that these cases were Dr. Monroe's.
8	Provide accurate and timely information	The disease index must be maintained continuously, and Chris Professional has a responsibility to keep it up-to-date. She could have discussed the situation with her boss to determine if temporary help could be arranged to maintain the index.
9	Confidentiality of information	Chris Professional does not have all the facts of this situation. To discuss privileged information from a committee meeting with a colleague in such a manner is inappropriate.

Professional Code of Ethics Assignment (Continued)

Case	Type of Ethical Breach	How Situation Should Have Been Handled to Avoid Breach of Ethics
10	Integrity and excellence through continuing education	The hospital approved Chris Professional's attendance at educational sessions, which they believe she attended. It is inappropriate for Chris to shop during times when she was expected to be in educational sessions. It is likely that if the hospital discovered this situation, they would not send her to future educational meetings (and they might question her ethics on the job at the facility).
11	Provide accurate information	Just because lab test results are positive does not necessarily mean the patient is diagnosed with the condition. Sometimes patients are carriers for diseases, and sometimes lab tests have false positive readings. Chris Professional should have referred this record to the patient's physician, who would be the health care provider responsible for documenting a diagnosis on the face sheet, if appropriate.
12	Confidentiality of patient information	Chris Professional certainly breached this patient's confidentiality. This hospital employee, as a patient, has the right to expect health care information to remain confidential. (In some facilities, hospital employee records are secured separately from regular patient records.)
13.	Confidentiality of patient information	Chris Professional should not have acknowledged that she knew that the patient was a resident.
14.	Conflict of interest and confidentiality	As a professional we should not discuss patient care or share patient information.
15.	Confidentiality of patient information	As a professional patient information should not be shared.

LAB ASSIGNMENT 2-5 Journal Abstract

The student will submit a word-processed one-page journal abstract, which should be evaluated to make sure it contains the following information:

- Name of article
- Name of author
- Name of journal
- Date of journal
- Journal article summary (paragraph format, double-spaced), which summarizes the article's content (and does not include the student's opinion about content of the article).

Chapter 3

Health Care Settings

LAB ASSIGNMENT 3-1 Health Care Facility Tour

The student should identify a health care facility to tour. (Or, as the instructor, you can arrange to take the entire class to tour a health care facility.) If this assignment is completed by the student outside of class, the instructor can require students to submit a summary of the experience (or, if teaching online, post a discussion).

LAB ASSIGNMENT 3-2 Joint Commission

The student should identify the types of facilities that are accredited by The Joint Commission. The student should then select a type of facility and prepare a two-page summary of the information that is found on The Joint Commission Web site relevant to the type of facility that was selected.

Chapter 4

The Patient Record: Hospital, Physician Office, and Alternate Care Settings

LAB ASSIGNMENT 4-1 Administrative and Clinical Data

Administrative and Clinical Data Item	Type of Element
Patient name	Demographic
Patient address, city, state, and zip code	Demographic
Telephone	Demographic
Gender	Demographic
Date of birth	Demographic
Patient number	Financial or Clinical
Admission date and time	Financial or Clinical
Primary insurance plan	Financial
Primary insurance plan ID #	Financial
Secondary insurance plan	Financial
Secondary insurance plan ID #	Financial
Occupation	Socioeconomic
Name of employer	Socioeconomic
Medication allergies/reactions	Clinical
Current medications	Clinical
BP, P, R, T, WT (vital signs)	Clinical
Chief complaint (CC)	Clinical
Past medical history (PMH)	Clinical
Notes	Clinical

LAB ASSIGNMENT 4-2 Provider Documentation Guidelines

Provider Documentation Responsibilities	Summary of Key Concepts
Authentication of Patient Record Entries	• Entry is signed by the author (e.g., health care provider) • Auto-authentication involves a provider authenticating a dictated report prior to its transcription • As a minimum, the facility must require that providers sign with their first initial, last name, and title/credential or discipline • As required by state law, only qualified health care providers may countersign an entry • Fax signatures can be accepted by facilities, as allowed by federal and state regulations • Electronic signatures can be accepted by facilities, as allowed by federal and state regulations • Rubber stamp signatures can be accepted by facilities if allowed by state and federal law
Abbreviations Used in the Patient Record	• Every health care facility should establish a policy as to which abbreviations can be documented in the patient record • The facility should maintain an official abbreviation list
Legibility of Patient Record Entries	• All entries in the patient record must be legible, and if an entry is illegible it should be rewritten by its author • The rewritten entry should state "Clarified entry of (date)" and contain exactly the same information as the original entry; it should be documented on the next available line in the record
Timeliness of Patient Record Entries	• Patient record entries should be documented as soon as possible after care is provided to increase accuracy of information recorded • Accrediting and licensing agencies require the timely completion of documentation • Medicare Conditions of Participation (CoP) for Hospitals require a complete physical examination to be performed no more than 30 days prior to admission or within 24 hours after admission • The Joint Commission requires patient records to be completed 30 days after patient discharged, at which time they become delinquent records • To calculate the delinquent record rate, divide the total number of delinquent records by the number of discharges in the period

Amending the Patient Record	• It is occasionally necessary to correct documentation in the patient record, which is called amending the patient record
	• The only person authorized to correct an entry is the author of the original entry
	• To amend an entry in a manual patient record system, the provider should:
	  • Draw a single line through the incorrect information, making sure that the original entry remains legible
	  • Date, time, and sign the corrected entry
	  • Document a reason for the error in a location as close to the original documentation as possible
	  • Enter the correct information as close to the original information as possible
	  • If the length of information to be newly entered prohibits this, enter the correct information in the next available space in the record and reference the original entry

Provider Documentation Responsibilities	Summary of Key Concepts
	• For electronic health record systems, errors will be corrected in a number of different ways, depending on the type of information that needs to be corrected • Basic principles for correcting documentation errors should be followed, and the electronic health record system should store both the original *and* corrected entry as well as a record of who documented both entries • Electronic health record systems will create a list of all changes made to patient documentation in the form of an audit trail • (HIPAA) Privacy Rule gives an individual the right to "have a covered entity that is a health care provider amend (or correct) protected health information (PHI) about him or her in designated record sets . . . for as long as the covered entity maintains the information" • The covered entity can deny the request for amendment or correction if the entry was not created by the covered entity, is not part of the designated record set, or is accurate and complete • A provider can amend an entry by adding an addendum to the record to *clarify* or add additional information about previous documentation or enter a *late entry;* the purpose of the addendum is to provide additional information, *not to change documentation,* and the addendum should be documented as soon after the original entry as possible

LAB ASSIGNMENT 4-3 Flow of Patient Information

Flow of Documentation	Responsible Staff Member or Physician
Face Sheet	Admissions staff (at patient admission) and attending physician (at patient discharge)
Admission Consent	Admissions staff
Nursing Assessment	Nursing staff
Physician Orders	Attending and other treating physicians
Admission History and Physical	Attending physician
Laboratory Test Results	Lab department performs tests, and attending or other treating physicians interpret results to direct patient treatment
Operative Note	Surgeon
Physical Therapy Exam and Treatment	Physical therapist performs treatment and documents notes, and attending or other treating physicians monitor progress to direct further patient treatment
Discharge Instructions	Attending physician documents instructions, and nursing staff discusses instructions with patient
Discharge Summary	Attending physician

LAB ASSIGNMENT 4-4 Medicare Conditions of Participation

Condition	Interpretation
(a) *Standard: Organization and staffing.* The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.	• Hospital must establish a medical record (or health information) department and provide appropriate physical space for it to perform its functions • Hospital must hire enough qualified individuals to perform tasks necessary to maintain patient records for the facility
(b) *Standard: Form and retention of record.* The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentification and protects the security of all record entries.	• Hospital must generate a patient record for each inpatient (stays overnight) and outpatient (ambulatory and emergency department patients) • Documentation by health care providers must be timely • Health information department must establish a system to consistently file/retrieve records so that records are accessible
(1) Medical records must be retained in their original or legally reproduced form for a period of at least 5 years.	• Hospital must establish a record retention policy, which requires records to be maintained (original, microfilm, or electronically) for a minimum of 5 years; even though the CoP doesn't specifically state this—if state statute requires longer retention period, the hospital must follow state requirements
(2) The hospital must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.	• Health information department must assign ICD and CPT/HCPCS codes to inpatient and outpatient records, and billing department must submit codes on claims to third-party payers • Codes must be abstracted (along with patient demographic information) to create indexes (e.g., disease, procedure, physician) so that records can be easily retrieved for the purpose of performing medical care evaluation (MCE) (or quality management) studies
(3) The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas.	• All patient information must be maintained in a confidential fashion, which means the physical record must be secure and the information contained in the record must be considered privileged • Security of the patient record also must ensure that unauthorized individuals do not have access and that the record cannot be tampered with in any way • Information from the patient record is not released unless patient authorization is obtained or in accordance with federal/state laws, subpoenas, or court orders
(c) *Standard: Content of record.* The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.	• Patient record must document all health care services provided to a patient, and is a repository of information that includes demographic data, and documentation to support diagnoses, justify treatment, and treatment results
(1) All entries must be legible and complete, dated, timed and authenticated in written or electronic format by the person responsible for providing, or evaluating the service provided, consistent with hospital policies and procedures.	• All entries in the patient record must be legible, and if an entry is illegible it should be rewritten by its author • Each patient record entry must be signed and dated by the responsible health care provider

Condition	Interpretation
(i) All orders, including verbal orders, must be dated, timed and authenticated promptly by the ordering practitioner, except as noted in paragraph (c) (1) (ii) of this section. (ii) For the 5-year period following January 26, 2007, all orders, including verbal orders, must be dated, timed and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under 482.12. (c) and authorized to write orders by hospital policy in accordance with State law. (iii) All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for authentication of verbal orders, verbal orders must be authenticated within 48 hours. (2) All records must document the following, as appropriate: (i) Evidence of (A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. (B) An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. (ii) For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under 482.12. (c) and authorized to write orders by hospital policy in accordance with State law. (iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.	▪ As a minimum, the facility must require that provider's sign with their first initial, last name, and title/credential or discipline ▪ Electronic signatures can be accepted for computer-based records, as allowed by federal and state regulations ▪ The attending physician must document the patient's history and physician no earlier than 30 days prior to inpatient admission or no more than 24 hours after admission ▪ The attending physician must document an admitting diagnosis in the inpatient record ▪ Consulting physicians must document an evaluation (examination) of the patient and pertinent findings ▪ The attending physician and other health care providers must document in the record any conditions that occur during admission, including nosocomial infections and adverse reactions to medications and anesthesia ▪ Patients must receive informed consent about procedures performed, and signed forms must be filed in the patient record ▪ Patient record must also include physician orders to direct treatment, nurses notes and progress notes to document patient's response to treatment, ancillary test results, documentation of vital signs in medical and nursing sections, and so on ▪ Attending physician must document a discharge summary (or clinical resume) that includes patient's hospital course, disposition, and plans for follow-up care ▪ Attending physician must document a final diagnosis (on discharge summary or face sheet) ▪ Patient record must be completed by all health care providers (physicians and hospital staff) within 30 days of patient discharge from the facility

Condition	Interpretation
(iv) Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.	
(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.	
(vi) All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.	
(vii) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.	
(viii) Final diagnosis with completion of medical records within 30 days following discharge.	

LAB ASSIGNMENT 4-5 Amending Patient Record Entries

Case No.	Correctly documented?	Justification statement:
1	❑ Yes ☑ No	The correction is missing the phrase "Error. Wrong dosage."
2	❑ Yes ☑ No	Do not obliterate an incorrect entry. Draw one line through the incorrect entry, write "Error. Wrong patient," and date and initial. Enter the correct entry in the proper patient's record.
3	❑ Yes ☑ No	Do not destroy the original transcribed report. Draw one line through each page, and write "Redictated" along with the date and initial. Place the new report in the record (on top of the previous report).
4	❑ Yes ☑ No	If the 0900 and 0945 entries were recorded as late entries, they should be labeled as such. If the nurse recorded the 1030 early (before medications were actually administered), the record should be forwarded to the risk manager for review. The nurse should also generate an incident report because of the charting error.
5	❑ Yes ☑ No	The correction is missing the phrase "Error. Wrong score" along with the author's initials next to the corrected entry.
6	☑ Yes ❑ No	In addition, the HIM clerk should alert the physician to the amendments in case the record needs to be corrected.
7	☑ Yes ❑ No	
8	❑ Yes ☑ No	The responsible physician could have manually edited the typographical errors. If a newly prepared note is preferred, the physician should draw one line through the erroneous note, and enter "Retyped" along with the date and initials. Place the new label on the next available progress note page, and if necessary, have the physician enter "Retyped note."
9	☑ Yes ❑ No	
10	☑ Yes ❑ No	

Chapter 5

Electronic Health Records

LAB ASSIGNMENT 5-1

The student should submit a two-page document that identifies an electronic health record system and the website for the system. The features of the system should be summarized. The student must discuss the types of facilities that would benefit from installation of the system.

LAB ASSIGNMENT 5-2

The student should submit a one-page document that summaries the AHIMA Practice Brief entitled "The Current State of PHRs." Topics discussed could include:

- The PHR and the Patient-Centric Model
- The Survey: Paper Still Dominant
- PHR Best Practices

LAB ASSIGNMENT 5-3

The student should submit a one-page document that summarizes the benefits of having a personal health record. This should be reflective of information that was viewed on www.myphr.com.

LAB ASSIGNMENT 5-4

The student should submit a 15-slide PowerPoint presentation on the benefits of electronic record systems. Benefits include: elimination of paper record storage, improvements in record access, control and legibility, timely capture of data, and reduction in administrative costs.

Chapter 6

Content of the Patient Record: Inpatient, Outpatient, and Physician Office

LAB ASSIGNMENT 6-1 Chart Assembly

Sequence	Reports
3	Advance Directives
9	Anesthesia Record
13	Ancillary Testing Reports
2	Consent To Admission
6	Consultation Reports
4	Discharge Summary
1	Face Sheet
5	History & Physical Examination
14	Nursing Section
10	Operative Report
12	Pathology Report
15	Patient Property Form
7	Physician Orders
8	Physician Progress Notes
11	Recovery Room Record

LAB ASSIGNMENT 6-2 Quantitative and Qualitative Analysis of Patient Records

Deficiency Slip

Patient Name: **M. Dennis** Patient Number: **Case01** Admission Date: **4-27-YYYY**

NAME OF REPORT	Dr[1]: **Thompson**	Dr[2]: **Galloway**	Dr[3]:
Inpatient Face Sheet	Sign (No Abbreviations) Complete Dx & Disch Instr.		
Discharge Summary	(Dictate) Sign		
History & Physical	(Dictate) Sign		
Consultation Report		Dictate Sign	Dictate Sign
Admission Progress Note	(Document) Date Sign		
Daily Progress Notes	Document Date (Sign)	Document Date (Sign)	Document Date Sign
Discharge Progress Note	(Document) Date Sign		
Physician Orders	Document Date (Sign)	Document Date Sign	Document Date Sign
Discharge Order	Document Date Sign		
Anesthesia Report		Document Sign	Document Sign
Preanesthesia Evaluation		Document Sign	Document Sign
Postanesthesia Evaluation		Document Sign	Document Sign
Operative Report	Dictate Sign	Dictate Sign	Dictate Sign
Pathology Report		Dictate Sign	Dictate Sign
Recovery Room Record		Document Sign	Document Sign
Radiology Report		Document Sign	Document Sign
Other: _____	Document Dictate	Document Dictate	Document Dictate
_____	Date Sign	Date Sign	Date Sign

Deficiency Slip

Patient Name: **D. Hunter** Patient Number: **Case02** Admission Date: **4-26-YYYY**

NAME OF REPORT	Dr[1]: **Ruddy**	Dr[2]:	Dr[3]:
Inpatient Face Sheet	Sign (No Abbreviations) Complete **Follow-up**		
Discharge Summary	(Dictate) Sign		
History & Physical	Dictate Sign		
Consultation Report		Dictate Sign	Dictate Sign
Admission Progress Note	Document Date Sign		
Daily Progress Notes	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Progress Note	(Document) Date Sign		
Physician Orders	Document Date (Sign)	Document Date Sign	Document Date Sign
Discharge Order	Document Date Sign		
Anesthesia Report		Document Sign	Document Sign
Preanesthesia Evaluation		Document Sign	Document Sign
Postanesthesia Evaluation		Document Sign	Document Sign
Operative Report	Dictate Sign	Dictate Sign	Dictate Sign
Pathology Report		Dictate Sign	Dictate Sign
Recovery Room Record		Document Sign	Document Sign
Radiology Report		Document Sign	Document Sign
Other: _____	Document Dictate	Document Dictate	Document Dictate
_____	Date Sign	Date Sign	Date Sign

Deficiency Slip

Patient Name: **E. Stanley** Patient Number: **Case03** Admission Date: **4-28-YYYY**

NAME OF REPORT	Dr[1]: **Wylie**	Dr[2]:	Dr[3]:
Inpatient Face Sheet	Sign No Abbreviations Complete _____		
Discharge Summary	(Dictate) Sign		
History & Physical	Dictate Sign		
Consultation Report		Dictate Sign	Dictate Sign
Admission Progress Note	Document Date Sign		
Daily Progress Notes	Document Date (Sign)	Document Date Sign	Document Date Sign
Discharge Progress Note	(Document) Date Sign		
Physician Orders	Document Date (Sign)	Document Date Sign	Document Date Sign
Discharge Order	Document Date Sign		
Anesthesia Report		Document Sign	Document Sign
Preanesthesia Evaluation		Document Sign	Document Sign
Postanesthesia Evaluation		Document Sign	Document Sign
Operative Report	(Dictate) Sign	Dictate Sign	Dictate Sign
Pathology Report		Dictate Sign	Dictate Sign
Recovery Room Record		Document Sign	Document Sign
Radiology Report		Document Sign	Document Sign
Other: _____ _____	Document Dictate Date Sign	Document Dictate Date Sign	Document Dictate Date Sign

Deficiency Slip

Patient Name: **M. Howe** Patient Number: **Case04** Admission Date: **4-29-YYYY**

NAME OF REPORT	Dr[1]: **Thompson**	Dr[2]:	Dr[2]:
Inpatient Face Sheet	Sign (No Abbreviations) Complete _____	NOTE: This is a 1-day stay, which means the physician can document a complete discharge progress note instead of dictating a discharge summary.	
Discharge Summary	Dictate Sign		
History & Physical	Dictate Sign		
Consultation Report		Dictate Sign	Dictate Sign
Admission Progress Note	(Document) Date Sign		
Daily Progress Notes	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Progress Note	(Document) Date Sign		
Physician Orders	Document Date (Sign)	Document Date Sign	Document Date Sign
Discharge Order	Document Date Sign		
Anesthesia Report		Document Sign	Document Sign
Preanesthesia Evaluation		Document Sign	Document Sign
Postanesthesia Evaluation		Document Sign	Document Sign
Operative Report	(Dictate) Sign	Dictate Sign	Dictate Sign
Pathology Report		Dictate Sign	Dictate Sign
Recovery Room Record		Document Sign	Document Sign
Radiology Report		Document Sign	Document Sign
Other: _____	Document Dictate	Document Dictate	Document Dictate
_____	Date Sign	Date Sign	Date Sign

Deficiency Slip

Patient Name: **A.Gibbon** Patient Number: **Case05** Admission Date: **4-27-YYYY**

NAME OF REPORT	Dr[1]: **Norris**	Dr[2]:	Dr[3]:
Inpatient Face Sheet	Sign No Abbreviations Complete _____		
Discharge Summary	(Dictate) Sign		
History & Physical	Dictate Sign		
Consultation Report		Dictate Sign	Dictate Sign
Admission Progress Note	Document Date Sign		
Daily Progress Notes	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Progress Note	(Document) Date Sign		
Physician Orders	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Order	(Document) Date Sign		
Anesthesia Report		Document Sign	Document Sign
Preanesthesia Evaluation		Document Sign	Document Sign
Postanesthesia Evaluation		Document Sign	Document Sign
Operative Report	Dictate Sign	Dictate Sign	Dictate Sign
Pathology Report		Dictate Sign	Dictate Sign
Recovery Room Record		Document Sign	Document Sign
Radiology Report		Document Sign	Document Sign
Other: _____	Document Dictate	Document Dictate	Document Dictate
_____	Date Sign	Date Sign	Date Sign

Deficiency Slip

Patient Name: **C. Benson** Patient Number: **Case06** Admission Date: **4-24-YYYY**

NAME OF REPORT	Dr[1]: **Thompson**	Dr[2]:	Dr[3]:
Inpatient Face Sheet	Sign (No Abbreviations) Complete **Diet**		
Discharge Summary	(Dictate) Sign		
History & Physical	(Dictate) Sign		
Consultation Report		Dictate Sign	Dictate Sign
Admission Progress Note	Document Date Sign		
Daily Progress Notes	Document Date (Sign)	Document Date Sign	Document Date Sign
Discharge Progress Note	Document Date Sign		
Physician Orders	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Order	Document Date Sign		
Anesthesia Report		Document Sign	Document Sign
Preanesthesia Evaluation		Document Sign	Document Sign
Postanesthesia Evaluation		Document Sign	Document Sign
Operative Report	Dictate Sign	Dictate Sign	Dictate Sign
Pathology Report		Dictate Sign	Dictate Sign
Recovery Room Record		Document Sign	Document Sign
Radiology Report		Document Sign	Document Sign
Other: _____	Document Dictate	Document Dictate	Document Dictate
_____	Date Sign	Date Sign	Date Sign

Deficiency Slip

Patient Name: H. Hoover Patient Number: Case07 Admission Date: 4-30-YYYY

NAME OF REPORT	Dr[1]: Swann	Dr[2]:	Dr[3]:
Inpatient Face Sheet	Sign No Abbreviations Complete _____		
Discharge Summary	(Dictate) Sign		
History & Physical	(Dictate) Sign		
Consultation Report		Dictate Sign	Dictate Sign
Admission Progress Note	Document Date Sign		
Daily Progress Notes	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Progress Note	(Document) Date Sign		
Physician Orders	Document Date (Sign)	Document Date Sign	Document Date Sign
Discharge Order	Document Date Sign		
Anesthesia Report		Document Sign	Document Sign
Preanesthesia Evaluation		Document Sign	Document Sign
Postanesthesia Evaluation		Document Sign	Document Sign
Operative Report	Dictate Sign	Dictate Sign	Dictate Sign
Pathology Report		Dictate Sign	Dictate Sign
Recovery Room Record		Document Sign	Document Sign
Radiology Report		Document Sign	Document Sign
Other: _____	Document Dictate	Document Dictate	Document Dictate
_____	Date Sign	Date Sign	Date Sign

Deficiency Slip

Patient Name: **M. Mason** Patient Number: **Case08** Admission Date: **4-28-YYYY**

NAME OF REPORT	Dr[1]: **Ghann**	Dr[2]:	Dr[3]:
Inpatient Face Sheet	Sign (No Abbreviations) Complete _____		
Discharge Summary	(Dictate) Sign		
History & Physical	Dictate Sign		
Consultation Report		Dictate Sign	Dictate Sign
Admission Progress Note	Document Date Sign		
Daily Progress Notes	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Progress Note	Document Date Sign		
Physician Orders	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Order	Document Date Sign		
Anesthesia Report		Document Sign	Document Sign
Preanesthesia Evaluation		Document Sign	Document Sign
Postanesthesia Evaluation		Document Sign	Document Sign
Operative Report	Dictate Sign	Dictate Sign	Dictate Sign
Pathology Report		Dictate Sign	Dictate Sign
Recovery Room Record		Document Sign	Document Sign
Radiology Report		Document Sign	Document Sign
Other: _____	Document Dictate	Document Dictate	Document Dictate
_____	Date Sign	Date Sign	Date Sign

Deficiency Slip

Patient Name: **D. Luck** Patient Number: **Case09** Admission Date: **5-1-YYYY**

NAME OF REPORT	Dr[1]: **Ghann**			Dr[2]:			Dr[3]:		
Inpatient Face Sheet	Sign	No Abbreviations							
	Complete	**Instructions**							
Discharge Summary	Dictate	Sign							
History & Physical	Dictate	Sign							
Consultation Report				Dictate	Sign		Dictate	Sign	
Admission Progress Note	Document	Date	Sign						
Daily Progress Notes	Document	Date	Sign	Document	Date	Sign	Document	Date	Sign
Discharge Progress Note	Document	Date	Sign						
Physician Orders	Document	Date	Sign	Document	Date	Sign	Document	Date	Sign
Discharge Order	Document	Date	Sign						
Anesthesia Report				Document	Sign		Document	Sign	
Preanesthesia Evaluation				Document	Sign		Document	Sign	
Postanesthesia Evaluation				Document	Sign		Document	Sign	
Operative Report	Dictate	Sign		Dictate	Sign		Dictate	Sign	
Pathology Report				Dictate	Sign		Dictate	Sign	
Recovery Room Record				Document	Sign		Document	Sign	
Radiology Report				Document	Sign		Document	Sign	
Other: _____	Document	Dictate		Document	Dictate		Document	Dictate	
_____	Date	Sign		Date	Sign		Date	Sign	

Deficiency Slip

Patient Name: **P. Paulson** Patient Number: **Case10** Admission Date: **4-26-YYYY**

NAME OF REPORT	Dr[1]: **Thompson**	Dr[2]:	Dr[2]:
Inpatient Face Sheet	Sign No Abbreviations Complete _____		
Discharge Summary	Dictate Sign		
History & Physical	Dictate Sign		
Consultation Report		Dictate Sign	Dictate Sign
Admission Progress Note	Document Date Sign		
Daily Progress Notes	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Progress Note	Document Date Sign		
Physician Orders	Document Date Sign	Document Date Sign	Document Date Sign
Discharge Order	Document Date Sign		
Anesthesia Report		Document Sign	Document Sign
Preanesthesia Evaluation		Document Sign	Document Sign
Postanesthesia Evaluation		Document Sign	Document Sign
Operative Report	Dictate Sign	Dictate Sign	Dictate Sign
Pathology Report		Dictate Sign	Dictate Sign
Recovery Room Record		Document Sign	Document Sign
Radiology Report		Document Sign	Document Sign
Other: _____	Document Dictate	Document Dictate	Document Dictate
_____	Date Sign	Date Sign	Date Sign

DEFICIENCY SLIP SUMMARY SHEET

Directions: After completing deficiency slips for Cases 6-10, transfer to this summary sheet. Submit to instructor.

Student Name **Answer Key**

	CASE06	CASE07	CASE08 *	CASE09	CASE10
INPATIENT FACE SHEET	Doctor Thompson Sign No Abbreviations Complete Diet	Doctor Swann Sign No Abbreviations Complete	Doctor Ghann Sign No Abbreviations Complete	Doctor Ghann Sign No Abbreviations Complete instructions	Doctor Thompson Sign No Abbreviations Complete Diet
DISCHARGE SUMMARY	Doctor Thompson Dictate Sign	Doctor Swann Dictate Sign	Doctor Ghann Dictate Sign	Doctor Ghann Dictate Sign	Doctor Thompson Dictate Sign
HISTORY & PHYSICAL	Doctor Thompson Dictate Sign	Doctor Swann Dictate Sign	Doctor Dictate Sign	Doctor Ghann Dictate Sign	Doctor Thompson Dictate Sign
CONSULTATION REPORT	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign
ADMISSION PROGRESS NOTE	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Ghann Document Date Sign	Doctor Ghann Document Date Sign	Doctor Thompson Document Date Sign
DAILY PROGRESS NOTE	Doctor Thompson Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign
	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Ghann * * Document Date Sign	Doctor Document Date Sign
DISCHARGE PROGRESS NOTE	Doctor Thompson Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Thompson Document Date Sign
PHYSICIAN ORDERS	Doctor Document Date Sign	Doctor Swann Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Thompson Document Date Sign
	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign
DISCHARGE ORDER	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Document Date Sign	Doctor Ghann * * * Document Date Sign	Doctor Document Date Sign
ANESTHESIA REPORT	Doctor Document Sign	Doctor Document Sign	Doctor Document Sign	Doctor Document Sign	Doctor Document Sign
PREANESTHESIA EVALUATION	Doctor Document Sign	Doctor Document Sign	Doctor Document Sign	Doctor Document Sign	Doctor Document Sign
POSTANESTHESIA EVALUATION	Doctor Document Sign	Doctor Document Sign	Doctor Document Sign	Doctor Document Sign	Doctor Document Sign
OPERATIVE REPORT	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign
PATHOLOGY REPORT	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign
RADIOLOGY REPORT	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign	Doctor Dictate Sign
OTHER	Doctor Document Dictate Date Sign	Doctor Document Dictate Date Sign	Doctor Document Dictate Date Sign	Doctor Document Dictate Date Sign	Doctor Document Dictate Date Sign

* The progress note error was corrected properly by Dr. Harris. Dr. Ghan is not required to edit this entry.

* * The progress note stated possible d/c, and the physician is responsible for documenting a discharge progress note that reflects the patient's actual discharge status.

* * * The last order states "If sats > 92% discharge to home." The attending physician should have checked sats and written a discharge order based on that information. Therefore, mark the deficiency slip as incomplete.

LAB ASSIGNMENT 6-3 Forms Design

Student should submit a redesigned operative report that includes hospital name, address, and phone number, patient identification section, and a form number and revision date. The form should include the following operative report elements:

- Preoperative diagnosis
- Postoperative diagnosis
- Procedure performed
- Surgeon
- Assistant surgeon
- Operative findings and procedure

Chapter 7

Numbering & Filing Systems and Record Storage & Circulation

LAB ASSIGNMENT 7-1 Straight Numeric and Terminal-Digit Filing

PART I: Re-sequence patient record numbers in straight numeric order (column 2) and terminal-digit order (column 3).

	Straight Numeric	Terminal Digit
031950	031950	878912
101075	061946	884325
212153	101075	213526
651473	129456	606339
451450	212153	061946
901895	213526	608946
608946	451450	619546
516582	516582	451450
878912	606339	031950
061946	608946	894851
990855	619546	212153
894851	625497	990855
619546	651473	129456
625497	878912	651473
884325	884325	101075
606339	894851	516582
129456	901895	901895
213526	990855	625497

PART II: Assign the next straight numeric and terminal-digit number for each.

	Straight Numeric	Terminal Digit
651430	651431	651530
845626	845627	845726
489225	489226	489325
231027	231028	231127
689212	689213	689312
948312	948313	848412
990855	990856	990955
894851	894852	894951
619546	619547	619646
625497	625498	625597
884325	884326	884425
606339	606340	606439
129456	129457	129556
213526	213527	213626

LAB ASSIGNMENT 7-2 Calculating Record Storage Needs

Case 1
10 × 50 = 500
10-shelf unit. 50 inches/shelf. 15,000 inches of current records. 8,000 projected inches needed for future.
15,000 + 8,000 = 23,000
23,000/500 = 46
Purchase 46 shelving units

Case 2
12-shelf unit. 150 inches/shelf. 21,000 inches of current records. 6,000 projected inches needed for future.
12 × 150 = 1,800
21,000 + 6,000 = 27,000
27,000/1,800 = 15
Purchase 15 shelving units

Case 3
20-shelf unit. 125 inches/shelf. 145,000 inches of current records. 20,000 projected inches needed for future.
20 × 125 = 2,500
145,000 + 20,000 = 165,000
165,000/2,500 = 66
Purchase 66 shelving units

Case 4
10-shelf unit. 135 inches/shelf. 27,000 inches of current records. 2,400 projected inches needed for future.
10 × 135 = 1,350
27,000 + 2,400 = 29,400
29,400/1,350 = 21.78
Purchase 22 shelving units

Case 5
15-shelf unit. 50 inches/shelf. 15,000 inches of current records. 10,000 projected inches needed for future.
15 × 50 = 750
15,000 + 10,000 = 25,000
25,000/750 = 33.33
Purchase 34 shelving units

LAB ASSIGNMENT 7-3 Guiding Terminal-Digit Files

NOTE: Standard rule of 50 records between file guides is used.

1. Hospital XYZ has 60,000 records in its terminal-digit file area.
   60,000/50 = 1,200 file guides
   1,200/100 = 12 secondary guides for each primary section
   100/12 = 8.3

Thus, for primary section 00, secondary guides will appear as:
00 08 00
00 16 00
00 24 00
00 32 00
etc.

2. Hospital ABC has 80,000 records in its terminal-digit file area.
80,000/50 = 1,600 file guides
1,600/100 = 16 secondary guides for each primary section
100/16 = 6.25
Thus, for primary section 00, secondary guides will appear as:
00 06 00
00 12 00
00 18 00
00 24 00
etc.

3. Hospital LMN has 100,000 records in its terminal-digit file area.
100,000/50 = 2,000 file guides
2,000/100 = 20 secondary guides for each primary section
100/20 = 5
Thus, for primary section 00, secondary guides will appear as:
00 05 00
00 10 00
00 15 00
00 20 00
etc.

LAB ASSIGNMENT 7-4 Assigning Pseudonumbers

Patient Name and Birthdate	Pseudonumber
Edward Francis Smart, 5/3/30	227-05-0330
Joseph Kenneth First, 9/18/37	442-09-1837
Eleanor Delores Comp, 7/4/45	221-07-0445
William David Love, 4/15/58	824-04-1558
Sherrie Rebecca Gage, 8/19/67	763-08-1967
Matthew David Brothers, 10/15/89	521-10-1589
Michelle Brittany Ash, 12/30/84	511-12-3084
Robert James Shumaker, 8/7/59	647-08-0759
Michaela Grace, 1/10/87	503-01-1087

LAB ASSIGNMENT 7-5 Assigning Soundex Codes

Anderson	A-536
Condor	C-536
Senator	S-536
Darlington	D-645
Goodyear	G-360
Levy	L-100
Shaw	S-000
Abbott	A-130
Farrell	F-640
Mann	M-500
Jackson	J-250
Biggs	B-200
McCarthy	M-263
Todt	T-300
Gjeljuag	G-422
Lloyd	L-300
Schkolnick	S-452
Skow	S-000
Henman	H-550

Chapter 8

Indexes, Registers, and Health Data Collection

LAB ASSIGNMENT 8-1 Case Abstracting

Students will submit 10 completed abstracts, based on Case01 through Case10.

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
0 2 0 9 Y Y Y Y
Month Day Year (YYYY)

03 Patient Gender
1 Male
2 Female
3 Other
4 Unknown
2

04A Race
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown
4

04B Ethnicity
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown
3

05A Living Arrangement
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown
7

05B Marital Status
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown
1

06 Patient Number
C A S E 0 1

07 Admission Date and Hour
0 4 2 7 Y Y Y Y
Month Day Year (YYYY)
0 8 0 0
Military Time

08 Type of Admission
1 Scheduled
2 Unscheduled
1

09 Discharge Date and Time
0 4 2 9 Y Y Y Y
Month Day Year (YYYY)
1 3 3 5
Military Time

10 Attending Physician Number
1 0 0 B 0 1

11 Operating Physician Number
1 0 0 B 0 1

12 Principal Diagnosis Code
6 1 6 . 0
ICD Code

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 1 5 Y Y Y Y
Month Day Year (YYYY)

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

17 Procedures, Dates, and Operating Physician UPIN

ICD Code	Qualifier	Month Day Year (YYYY)	UPIN
6 9 . 0 9		0 4 2 7 Y Y Y Y	1 0 0 B 0 1
6 7 . 2		0 4 2 7 Y Y Y Y	1 0 0 B 0 1

15 External Cause of Injury Codes
ICD E-code
ICD E-code
ICD E-code
ICD E-code
ICD E-code

18 Disposition
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died
1

19 Patient's Expected Payment Source
1
1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other

20 Total Charges
$ 4,954.40

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
0 9 2 2 Y Y Y Y
Month Day Year (YYYY)

03 Patient Gender 1
1 Male
2 Female
3 Other
4 Unknown

04A Race 4
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown

04B Ethnicity 3
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown

05A Living Arrangement 7
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown

05B Marital Status 1
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown

06 Patient Number
C A S E 0 2

07 Admission Date and Hour
0 4 2 6 Y Y Y Y
Month Day Year (YYYY)
1 5 2 0
Military Time

08 Type of Admission 2
1 Scheduled
2 Unscheduled

09 Discharge Date and Time
0 4 2 9 Y Y Y Y
Month Day Year (YYYY)
1 0 1 0
Military Time

10 Attending Physician Number
1 0 0 T 3 2

11 Operating Physician Number
1 0 0 T 3 2

12 Principal Diagnosis Code
4 6 6 . 0
ICD Code

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 1 5 Y Y Y Y
Month Day Year (YYYY)

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

ICD Code	14
4 9 3 . 9 0	1
4 9 6.	1
4 0 1 . 9	1

17 Procedures, Dates, and Operating Physician UPIN

	Month Day Year (YYYY)	UPIN
.		
.		
.		
.		
.		
.		
.		

15 External Cause of Injury Codes
ICD E-code
ICD E-code
ICD E-code
ICD E-code
ICD E-code

18 Disposition 1
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died

19 Patient's Expected Payment Source 2
1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other

20 Total Charges
$ 2,692.74

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
0 4 0 5 Y Y Y Y
Month Day Year (YYYY)

03 Patient Gender
1 Male
2 Female
3 Other
4 Unknown
2

04A Race
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown
4

04B Ethnicity
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown
3

05A Living Arrangement
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown
7

05B Marital Status
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown
1

06 Patient Number
C A S E 0 3

07 Admission Date and Hour
0 4 2 8 Y Y Y Y
Month Day Year (YYYY)
0 6 2 0
Military Time

08 Type of Admission
1 Scheduled
2 Unscheduled
1

09 Discharge Date and Time
0 4 2 9 Y Y Y Y
Month Day Year (YYYY)
1 0 2 0
Military Time

10 Attending Physician Number
1 0 0 D 4 3

11 Operating Physician Number
1 0 0 D 4 3

12 Principal Diagnosis Code
5 7 5 . 1 1
ICD Code

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 1 5 Y Y Y Y
Month Day Year (YYYY)

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

ICD Code

17 Procedures, Dates, and Operating Physician UPIN

5 1 . 2 3	0 4 2 8 Y Y Y Y Month Day Year (YYYY)	1 0 0 D 4 3 UPIN
.	Month Day Year (YYYY)	UPIN
.	Month Day Year (YYYY)	UPIN
.	Month Day Year (YYYY)	UPIN
.	Month Day Year (YYYY)	UPIN
.	Month Day Year (YYYY)	UPIN
.	Month Day Year (YYYY)	UPIN
.	Month Day Year (YYYY)	UPIN

15 External Cause of Injury Codes
ICD E-code

18 Disposition
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died
1

19 Patient's Expected Payment Source
1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other
5

20 Total Charges
$ 3,500.50

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
0 3 | 3 1 | Y Y Y Y
Month Day Year (YYYY)

03 Patient Gender 2
1 Male
2 Female
3 Other
4 Unknown

04A Race 4
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown

04B Ethnicity 3
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown

05A Living Arrangement 7
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown

05B Marital Status 2
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown

06 Patient Number
C A S E 0 4

07 Admission Date and Hour
0 4 | 2 9 | Y Y Y Y
Month Day Year (YYYY)
0 9 0 0
Military Time

08 Type of Admission 1
1 Scheduled
2 Unscheduled

09 Discharge Date and Time
0 4 | 2 9 | Y Y Y Y
Month Day Year (YYYY)
1 6 0 0
Military Time

10 Attending Physician Number
1 0 0 B 0 1

11 Operating Physician Number
1 0 0 B 0 1

12 Principal Diagnosis Code
8 0 2 . 0
ICD Code

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 | 1 5 | Y Y Y Y
Month Day Year (YYYY)

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

17 Procedures, Dates, and Operating Physician UPIN

ICD Code	14	Month Day Year (YYYY)	UPIN
2 1 . 7 2		0 4 | 2 9 | Y Y Y Y	1 0 0 B 0 1
2 1 . 8 1		0 4 | 2 9 | Y Y Y Y	1 0 0 B 0 1
8 7 3 . 2 0	1		

15 External Cause of Injury Codes
E 8 1 9 . 1 2
ICD E-code

18 Disposition 1
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died

19 Patient's Expected Payment Source 5
1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other

20 Total Charges
$ 1,850.75

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
0 8 | 1 9 | Y Y Y Y
Month Day Year (YYYY)

03 Patient Gender
1 Male
2 Female
3 Other
4 Unknown
1

04A Race
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown
4

04B Ethnicity
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown
3

05A Living Arrangement
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown
7

05B Marital Status
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown
1

06 Patient Number
C A S E 0 5

07 Admission Date and Hour
0 4 | 2 7 | Y Y Y Y
Month Day Year (YYYY)
1 3 0 0
Military Time

08 Type of Admission
1 Scheduled
2 Unscheduled
2

09 Discharge Date and Time
0 4 | 2 9 | Y Y Y Y
Month Day Year (YYYY)
0 0 0 0
Military Time

10 Attending Physician Number
1 0 0 G 0 2

11 Operating Physician Number

12 Principal Diagnosis Code
7 8 6 . 5 0
ICD Code

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 | 1 5 | Y Y Y Y
Month Day Year (YYYY)

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

ICD Code	14
4 0 1 . 9	1
4 2 9 . 9	1
4 4 0 . 9	1
4 1 2 .	1
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17 Procedures, Dates, and Operating Physician UPIN

	Month Day Year (YYYY)	UPIN
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15 External Cause of Injury Codes
ICD E-code
ICD E-code
ICD E-code
ICD E-code
ICD E-code

18 Disposition
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died
1

19 Patient's Expected Payment Source
4
1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other

20 Total Charges
$ 4,855.65

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
1 2 1 3 Y Y Y Y
Month Day Year (YYYY)

03 Patient Gender
1 Male
2 Female
3 Other
4 Unknown
[1]

04A Race
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown
[4]

04B Ethnicity
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown
[3]

05A Living Arrangement
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown
[7]

05B Marital Status
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown
[1]

06 Patient Number
C A S E 0 6

07 Admission Date and Hour
0 4 2 4 Y Y Y Y
Month Day Year (YYYY)
1 4 3 0
Military Time

08 Type of Admission
1 Scheduled
2 Unscheduled
[2]

09 Discharge Date and Time
0 4 2 9 Y Y Y Y
Month Day Year (YYYY)
1 0 0 0
Military Time

10 Attending Physician Number
1 0 0 B 0 1

11 Operating Physician Number

12 Principal Diagnosis Code
7 3 3 . 6
ICD Code

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 1 5 Y Y Y Y
Month Day Year (YYYY)

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

ICD Code	14
4 2 9 . 9	1
4 4 0 . 9	1
4 1 2 .	1
V 1 2 . 5 9	1
V 4 5 . 8 1	1
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17 Procedures, Dates, and Operating Physician UPIN

	Month Day Year (YYYY)	UPIN
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15 External Cause of Injury Codes

ICD E-code
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18 Disposition
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died
[1]

19 Patient's Expected Payment Source
[4]

1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other

20 Total Charges
$ 2,335.50

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
0 1 | 1 6 | Y Y Y Y
Month Day Year (YYYY)

03 Patient Gender
1 Male
2 Female
3 Other
4 Unknown
2

04A Race
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown
4

04B Ethnicity
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown
3

05A Living Arrangement
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown
7

05B Marital Status
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown
1

06 Patient Number
C A S E 0 7

07 Admission Date and Hour
0 4 | 3 0 | Y Y Y Y
Month Day Year (YYYY)
1 5 4 5
Military Time

08 Type of Admission
1 Scheduled
2 Unscheduled
2

09 Discharge Date and Time
0 5 | 0 2 | Y Y Y Y
Month Day Year (YYYY)
1 0 1 0
Military Time

10 Attending Physician Number
1 0 0 V 2 3

11 Operating Physician Number

12 Principal Diagnosis Code
5 3 0 . 1 1
ICD Code

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 | 1 5 | Y Y Y Y
Month Day Year (YYYY)

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

ICD Code	
5 5 3 . 3	1

17 Procedures, Dates, and Operating Physician UPIN

	Month Day Year (YYYY)	UPIN
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15 External Cause of Injury Codes
ICD E-code
ICD E-code
ICD E-code
ICD E-code
ICD E-code

18 Disposition
1
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died

19 Patient's Expected Payment Source
1
1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other

20 Total Charges
$ 1,555.95

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
0 3 0 1 Y Y Y Y
Month Day Year (YYYY)

03 Patient Gender
1 Male
2 Female
3 Other
4 Unknown
2

04A Race
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown
4

04B Ethnicity
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown
3

05A Living Arrangement
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown
7

05B Marital Status
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown
2

06 Patient Number
C A S E 0 8

07 Admission Date and Hour
0 4 2 8 Y Y Y Y
Month Day Year (YYYY)
2 3 3 0
Military Time

08 Type of Admission
1 Scheduled
2 Unscheduled
2

09 Discharge Date and Time
0 5 0 2 Y Y Y Y
Month Day Year (YYYY)
1 3 0 0
Military Time

10 Attending Physician Number
1 0 0 A 9 0

11 Operating Physician Number

12 Principal Diagnosis Code
4 6 6 . 1 1
ICD Code

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 1 5 Y Y Y Y
Month Day Year (YYYY)

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

ICD Code	Qualifier
0 7 9 . 6	1

17 Procedures, Dates, and Operating Physician UPIN

	Month Day Year (YYYY)	UPIN
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15 External Cause of Injury Codes
ICD E-code
ICD E-code
ICD E-code
ICD E-code
ICD E-code

18 Disposition
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died
1

19 Patient's Expected Payment Source
1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other
1

20 Total Charges
$ 2 , 6 0 5 . 3 5

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
1 1 (Month) 2 1 (Day) Y Y Y Y (Year (YYYY))

03 Patient Gender
1 Male
2 Female
3 Other
4 Unknown
2

04A Race
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown
4

04B Ethnicity
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown
3

05A Living Arrangement
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown
7

05B Marital Status
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown
1

06 Patient Number
C A S E 0 9

07 Admission Date and Hour
0 5 (Month) 0 1 (Day) Y Y Y Y (Year (YYYY))
1 1 3 0 (Military Time)

08 Type of Admission
1 Scheduled
2 Unscheduled
2

09 Discharge Date and Time
0 5 (Month) 0 2 (Day) Y Y Y Y (Year (YYYY))
1 1 5 0 (Military Time)

10 Attending Physician Number
1 0 0 A 9 0

11 Operating Physician Number

12 Principal Diagnosis Code
4 9 3 . 9 2 (ICD Code)

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 (Month) 1 5 (Day) Y Y Y Y (Year (YYYY))

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

ICD Code	Qualifier
2 7 6 . 2	1
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17 Procedures, Dates, and Operating Physician UPIN

ICD Code	Month Day Year (YYYY)	UPIN
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15 External Cause of Injury Codes

ICD E-code
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18 Disposition
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died
1

19 Patient's Expected Payment Source
1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other
2

20 Total Charges
$ 1,955.95

ALFRED STATE MEDICAL CENTER ACUTE CARE (INPATIENT) CASE ABSTRACT

01 Hospital Number
0 0 0 9 9 9

02 Patient Date of Birth
0 1 2 0 Y Y Y Y
Month Day Year (YYYY)

03 Patient Gender
1 Male
2 Female
3 Other
4 Unknown
2

04A Race
1 American Indian/Eskimo/Aleut
2 Asian or Pacific Islander
3 Black
4 White
5 Other
6 Unknown
4

04B Ethnicity
1 Spanish origin/Hispanic
2 Non-Spanish origin/Non-Hispanic
3 Unknown
3

05A Living Arrangement
1 Alone
2 With spouse
3 With children
4 With parent or guardian
5 With relative other than spouse
6 With nonrelatives
7 Unknown
7

05B Marital Status
1 Married
2 Single
3 Divorced
4 Separated
5 Unknown
1

06 Patient Number
C A S E 1 0

07 Admission Date and Hour
0 4 2 6 Y Y Y Y
Month Day Year (YYYY)
1 6 0 0
Military Time

08 Type of Admission
1 Scheduled
2 Unscheduled
2

09 Discharge Date and Time
0 5 0 1 Y Y Y Y
Month Day Year (YYYY)
0 9 3 0
Military Time

10 Attending Physician Number
1 0 0 B 0 1

11 Operating Physician Number

12 Principal Diagnosis Code
4 6 6 . 0
ICD Code

16 Birth Weight of Neonate
Kilograms

Date Abstract Completed
0 1 1 5 Y Y Y Y
Month Day Year (YYYY)

13 Other Diagnosis Code(s)

14 Qualifiers for Other Diagnoses
1 Onset preceded hospital admission
2 Onset followed hospital admission
3 Uncertain whether onset preceded or followed hospital admission

ICD Code	14
4 9 6 .	1
5 1 8 . 8 9	1
4 2 8 . 0	1

17 Procedures, Dates, and Operating Physician UPIN

	Month Day Year (YYYY)	UPIN
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15 External Cause of Injury Codes
ICD E-code
ICD E-code
ICD E-code
ICD E-code
ICD E-code

18 Disposition
1
1 Discharged to home
2 Discharged to acute care hospital
3 Discharged to nursing facility
4 Discharged home to be under the care of a home health service (including hospice)
5 Discharged to other health care facility
6 Left against medical advice (AMA)
7 Alive, other
8 Died

19 Patient's Expected Payment Source
1
1 Blue Cross/Blue Shield
2 Other commercial insurance
3 Other liability insurance
4 Medicare
5 Medicaid
6 Workers' Compensation
7 Self-insured employer plan
8 Health maintenance organization (HMO)
9 TRICARE
10 CHAMPVA
11 Other government payer
12 Self-pay
13 No charge (e.g., charity, special research, teaching)
14 Other

20 Total Charges
$ 7 , 2 3 6 . 9 5

LAB ASSIGNMENT 8-2 Master Patient Index Data Entry

Student will submit completed MPI form.

1. LAST NAME	2. FIRST NAME	3. MIDDLE NAME	4. GENDER	5. AGE	6. RACE	7. PATIENT NUMBER
Dennis	Marsha		F	[1]	W	Case01

8. ADDRESS	9. DATE OF BIRTH			10. THIRD PARTY PAYERS
	a. MONTH	b. DAY	c. YEAR	
344 Maple Avenue				BCBS of WNY
Alfred, NY 14802	02	09	YYYY	

11. MAIDEN NAME	12. PLACE OF BIRTH	13. SOCIAL SECURITY NUMBER (SSN)
Taylor	[2]	[3]

14. ADMISSION DATE	15. DISCHARGE DATE	15. PROVIDER	17. TYPE	18. DISCHARGE STATUS
0427YYYY	0429YYYY	THOMPSON	IP	HOME

[1]Age cannot be calculated due to use of YYYY as year on practice cases.

[2]The record did not indicate place of birth; therefore, leave blank.

[3]The record did not indicate social security number; therefore, leave blank.

LAB ASSIGNMENT 8-3 Disease, Procedure, and Physician Indexes

1. a. Principal diagnosis, using an ICD-9-CM disease code
   b. Principal procedure, using an ICD-9-CM procedure code
   c. Physician name
   d. Six different attending physicians
   e. Four different attending physicians
   f. Average age is 34
2. a. Youngest patient is 8, oldest patient is 88 (procedure index)
   b. Secondary diagnosis codes include 250.00, 401.9, and 496 (disease index)
   c. Patient numbers include 236268, 562159, and 236954 (physician index)
   d. Patient numbers include 236248, 123456, and 213654 (disease index)
   e. Age 80 (physician index)

Chapter 9

Legal Aspects of Health Information Management

LAB ASSIGNMENT 9-1 Notice of Privacy Practices

Student will submit a brief summary of deficiencies found upon review of the Notice of Privacy Practices found in Figure 9-1 of the *Lab Manual*. The following elements of the notice of privacy practices are missing:

1. A header: "THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."
2. A description, including at least one example of the types of uses and disclosures that the covered entity is permitted to make for treatment, payment, and health care operations.
3. A statement of the individual's rights with respect to protected health information and a brief description of how the individual may exercise these rights, including:
   - The right to request restrictions on certain uses and disclosures as provided by 45 CFR 164.522(a), including a statement that the covered entity is not required to agree to a requested restriction
   - The right to receive confidential communications of protected health information as provided by 164.522(b), as applicable
   - The right to inspect and copy protected health information as provided by 164.524
   - The right to amend protected health information as provided in 164.526
   - The right to receive an accounting of disclosures as provided in 164.528
   - The right to obtain a paper copy of the notice upon request as provided in 164.520
4. A statement that individuals may complain to the Secretary of Health and Human Services if they believe their privacy rights have been violated.

LAB ASSIGNMENT 9-2 Release of Patient Information

See Figure 9-2 in the *Lab Manual.*

1. No. HIPAA makes it illegal to allow law enforcement agency representatives to access protected health information (PHI) unless they produce a signed patient authorization to release information or a court document (e.g., court order, *subpoena duces tecum*).
2. No. The patient's signature on the release of information authorization was obtained prior to his discharge from the facility. Therefore, you cannot release the information requested to the insurance company.

NOTE: The signature on the release of information authorization must be dated after treatment has concluded (e.g., after date of discharge from inpatient hospitalization). The patient doesn't know what will occur during treatment, and he may not want some aspect of his records released (e.g., HIV-positive lab result). In this particular case, you would instruct the insurance company to obtain an updated, signed authorization to release medical record information from the patient (dated after discharge from the hospital).

3. Yes. This is an example of the secondary use of medical record information. In this situation, the student isn't requesting access to specific patient records; therefore, you allow her to access the medical records to complete her research project.

NOTE: In this situation, you would need to verify the student's status with her academic program and supervise her review of medical records (to ensure that no records are removed, tampered with, and so on).

4. Yes. When a record copy service (e.g., SMART Corporation) is routinely used to process release of information requests that are properly executed, it is acceptable to have the service process court documents (e.g., court order, *subpoena duces tecum*).

NOTE: Record copy services are very popular because the service sends staff to your facility to process requests for information that have been properly executed. You check each request for information to make sure it is legal to process, and the service retrieves the record, makes copies of pertinent documents, mails the copies, and refiles the records. The service makes their money by billing the requesting organization (e.g., insurance company, lawyer, and so on) for copies. Most services will also process requests for information that are typically processed for no charge (e.g., physicians). Quite often the *subpoena duces tecum,* signed by the court clerk (or court order, signed by the judge) will state that copies of records can be mailed intead of your appearing in court with original records. In addition, the *subpoena duces tecum* for this case specifies an alternative method for complying other than making a (time-consuming) personal appearance. This is common practice, and it is perfectly acceptable to respond to court documents in this way.

5. No. The minister must present a signed authorization to release information from the patient before he can view the patient's medical records.

NOTE: No hospital employee has the right to view any patient's medical record at any time. Only those health care employees (e.g., nurse, therapists, and so on) who participated in a patient's treatment can view a patient's medical record. A hospital chaplain is not considered a health care employee; therefore, he would be required to obtain the patient's signed authorization to release information before he could view the patient's record.

6. No. This facility has a formal arrangement for their lab technicians to draw blood from patients who are involved in a criminal case. The coroner's office is responsible for transport of specimens from the facility. Even though the blood vial was destroyed in transport, the facility does not have an obligation to provide information from the patient's record. In fact, it is illegal for the facility to release information from the patient's record without first obtaining a signed authorization to release information from the patient.

NOTE: Even though television shows such as *CSI* (and *CSI: Miami*) depict sophisticated forensic facilities, they are rare in the United States. For example, the Southern Tier of New York State has just one forensics lab, and they contract with local hospitals to perform blood draws and such on patients involved in crimes (e.g., DUI cases). Even though this formal contract arrangement is in place, it is illegal for the facility to release infor-mation from patient medical records unless the patient has signed an authorization (or a court document is presented).

7. Yes. The patient authorization to release information is properly executed. Therefore, the district attorney can be allowed to review the patient's medical records.

NOTE: When you allow the district attorney (or anyone) to review the patient's medical record(s), be sure to supervise the review so that the records are not removed, tampered with, and so on.

8. No. Law enforcement agencies must obtain patient authorization to release information (or court documents, such as court order or *subpoena duces tecum*) before information from a patient's medical record may be released.

NOTE: The telephone call-back method is not used in this situation. It is used to verify the authenticity of a health care facility/professional (e.g., emergency department physician) requesting medical information about a patient in an emergency situation (e.g., history of medications on a patient who is comatose).

9. Yes. Once you obtain proof that the physician is authentic and is treating the patient, according to HIPAA provisions he has the right to access patient information without express patient authorization to provide for continuity of care. Be sure the physician reviews the record in a supervised area of the health information department.

NOTE: It used to be that only physicians on your facility's medical staff could review patient records for continuity of care purposes. HIPAA changed that and eliminated the requirement for express patient authorization when a legitimate health care professional (e.g., one who is currently treating the patient) needs to access records for patient care purposes.

10. Yes. Verify that this is an emergency situation by using the call-back method. Once the situation is verified, release the information via telephone (or fax) and request that the ED physician arrange for a signed authorization to release information be submitted once the patient's condition has stabilized.

NOTE: Ideally, we would require a signed authorization to release information prior to releasing any patient information. Emergency situations, however, are special cases and we routinely use the call-back method to comply with urgent requests for information because the patient's care could be compromised otherwise. The telephone call-back method verifies the authenticity of a health care facility/professional (e.g., ED physician) requesting medical information about a patient in an emergency situation (e.g., history of medications on a patient who is comatose). To implement the call-back method, you look up the switchboard number of the health care facility in the phone book (or by calling Information), call the switchboard, ask to be connected to the appropriate department (e.g., ED), and then ask to speak with the health care professional responsible for the patient. This ensures that you are appropriately releasing information via telephone. You then follow up by requiring the facility to submit a release of information authorization signed by the patient or next of kin (so you have it for your file).

LAB ASSIGNMENT 9-3 Release of Information Correspondence Log

Correspondence Log

Case	Type of Request	Is Request Appropriate? (If No, Why Not?)	Response Form Letter Sent	Reports Released and Charge
1	Physician	Yes	B	Entire record $0.00
2	BCBS	Yes[1]	A	Face sheet, H&P $1.50
3	Physician	Yes	B	Face sheet, H&P $0.00
4	Attorney	No; missing patient authorization	D	None $0.00
5	Hospital	Yes	B	Face sheet, H&P, Lab, X-ray $0.00
6	Commercial Insurance	No; authorization is not HIPAA-compliant	D	None $0.00
7	BCBS	Yes[1]	A	Face sheet, H&P, Discharge summary[2] $3.75
8	*Subpoena duces tecum*	Yes	A	Entire record $10.50
9	*Subpoena duces tecum*[3]	Yes	A	Entire record $12.00
10	Physician	Yes	B	Blood profile (HIV)

[1]BCBS and Medicare do not require patient authorization to receive records. When patients sign a BCBS contract or enroll in Medicare, they authorize release of information for the purpose of reimbursement.
[2]To comply with this request for information, the responsible physician should dictate and authenticate the discharge summary and history/physical examination.
[3]This court-ordered *subpoena duces tecum* was signed by the clerk of the court; therefore, it is a *subpoena duces tecum* (not a court order, which would be signed by a judge).

LAB ASSIGNMENT 9-4 Telephone Calls for Release of Information Processing

Simulation #1:

- How would you rate the RHIT's greeting?

  She should have stated her name.

- Did the RHIT respond appropriately to the patient's request?

  Yes.

- Do you agree with the RHIT's reason for not releasing records immediately to the new physician? Why or why not?

  HIPAA states that patient authorization is not needed to release information to a treating provider. The RHIT should have explained that it is facility policy to require the patient to sign an authorization.

- What is the significance of the RHIT using the patient's name during the conversation?

  It personalizes the call and makes the person feel as though the RHIT is paying attention to her.

- What would you have said differently from that in the scenario?

  I would have explained facility policy about requiring a patient authorization to release information to a physician.

Simulation #2:

- How would you rate the MA's phone response?

  The MA should have stated her name.

- Did the MA respond appropriately to the request?

  Yes.

- What would you have said differently from that in the scenario?

  Nothing.

Simulation #3:

- Critique Barbara's greeting.

  Barbara should have stated her name.

- Determine how you would handle this situation if you were Barbara. What would you have done differently, if anything, from the onset?

  Barbara should have taken the doctor's name and phone number so she could implement the emergency call-back procedure. By leaving the physician on hold, she is giving the impression that she will be locating the record and releasing information over the phone. This is inappropriate because the physician's identify has not yet been verified. (This could be a call from someone hoping to illegally gain access to patient information.)

- Given the above situation, what would you do next?

  Once Barbara determined that the record was a sealed file, she should immediately notify her supervisor of the call. It is likely that the facility attorney will be contacted to provide advice on how to proceed.

Simulation #4:

- What information can be released over the telephone?

  Most facilities establish a policy that no information is related over the telephone (except in emergency situations for which the call-back procedure is implemented).

- What information should Susie have requested from the caller?

  Susie should have explained that a HIPAA-compliant authorization to release patient information is required, and that the request for information will be processed in writing.

- What release of information protocol did Susie violate?

  Susie breached patient confidentiality by releasing information (over the telephone) without first obtaining an authorization from the patient.

LAB ASSIGNMENT 9-5 Statement of Confidentiality

The student will submit a signed and dated statement of confidentiality.

Chapter 10

Coding and Reimbursement

LAB ASSIGNMENT 10-1 Hospital Financial Reports

Alfred Medical Center Financial Report – June YYYY				
Principal Dx	DRG Assignment	Base Payment	Number of Cases	Reimbursement
041.02	423	$ 4,730.28	25	$ 118,257.00
616.10	368	$ 3,421.55	32	$ 109,489.60
646.61	372	$ 2,730.16	15	$ 40,952.40
646.81	372	$ 2,730.16	41	$ 111,936.56
648.81	372	$ 2,730.16	11	$ 30,031.76
663.31	372	$ 2,730.16	27	$ 72,714.32
V27.0	467	$ 1,349.05	31	$ 41,820.55
			Total for June YYYY	$ 525,202.19

LAB ASSIGNMENT 10-2 Updating Clinic Encounter Form

ALFRED STATE MEDICAL CENTER OUTPATIENT CLINIC

Patient Name: _____ Provider number: _____

Address: _____ Primary Insurance: _____

Reason for encounter: _____ Appointment time: _____

Encounter #: _____ Date: _____

CODE	DESCRIPTION
Office Visits	
99201	New Patient - level 1
99202	New Patient - level 2
99203	
~~99303~~	New Patient - level 3
99204	New Patient - level 4
99205	New Patient - level 5
99211	Established Patient - level 1
99212	Established Patient - level 2
99213	Established Patient - level 3
99214	Established Patient - level 4
99215	Established Patient - level 5
Procedures	
58300	IUD Insertion
93005	Electrocardiogram
92552	Audiometry
92567	Tympanometry
69210	Ear Lavage
94640	
~~94650~~	IPPB treatment
94010	Spirometry
94760	Pulse Oximetry
Therapy	
97001	PT Evaluation
97002	
~~97004~~	PT Re-evaluation
97003	OT Evaluation
97004	OT Re-evaluation

CODE	DESCRIPTION
Laboratory	
81001	Urinalysis with microscopy
82044	Urine—Microalbumin
82947	Blood Glucose
85014	Hematocrit
85611	Protime
86580	PPD
87880	
~~87060~~	Strep Screen
Diagnosis	
466.0	Bronchitis, acute
491.9	
~~466~~	Bronchitis, chronic
786.50	Chest Pain
786.2	Cough
401.9	Hypertension
382.9	
~~381.9~~	Otitis
724.5	Pain, back
719.50	Pain, joint

Next Appointment: _____ Provider Signature _____

LAB ASSIGNMENT 10-3 ICD-10 Implementation in the United States

The student will submit a one-page report that includes the following elements:

- ICD-10 is used to code and classify mortality data from death certificates, having replaced ICD-9 for this purpose as of January 1, 1999.
- WHO has authorized development of an adaptation of ICD-10 for use in the United States for U.S. government purposes.
- National Center for Health Statistics (NCHS) is the federal agency responsible for use of International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) in the United States.
- NCHS developed a clinical modification of the classification for morbidity purposes, entitled ICD-10-CM.
- ICD-10-CM is planned as the replacement for ICD-9-CM, Volumes 1 and 2. ICD-10-PCS is being developed as a replacement for ICD-9-CM, Volume 3.
- ICD-10 is copyrighted by the World Health Organization (WHO), which owns and publishes the classification.
- All modifications to the ICD-10 must conform to WHO conventions for the ICD.
- Except in rare instances, no modifications have been made to existing three-digit categories and four-digit codes, with the exception of title changes that did not change the meaning of the category or code.
- Current draft of ICD-10-CM contains a significant increase in codes over ICD-10 and ICD-9-CM.
- Notable improvements in ICD-10-CM content and format include the addition of information relevant to ambulatory and managed care encounters; expanded injury codes; the creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition; the addition of a sixth character; incorporation of common 4th- and 5th-digit subclassifications; laterality; and greater specificity in code assignment.
- ICD-10-CM will allow further expansion than was possible with ICD-9-CM.
- Testing of ICD-10-CM will occur using a pre-release version; updates to this draft will occur prior to implementation of ICD-10-CM.
- The implementation date for ICD-10-CM/ICD-10-PCS is October 1, 2013.
- Implementation will be based on the process for adoption of standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- There will be a 2-year implementation window once the final notice to implement has been published in the *Federal Register.*

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